HARKINS, LAURA E., M.S. Administrative Perspectives of Recreational Therapy Services in North Carolina. (2010)
Directed by Leandra A. Bedini. 137 pp.

The purpose of this study was to survey key supervisory staff at North Carolina health care facilities to (a) identify the existence and competitive positions of recreational therapy (RT) services, and (b) understand the rationale driving health care facility decisions related to the provision of RT programs to their clients. The sample comprised 419 participants who were predominantly Caucasian, females, and administrators between the ages of 46-55.

Relevant literature and the consensus of selected recreational therapy and non-recreational therapy professionals assisted with survey development. The survey included items to determine the existence of RT services, knowledge and perceptions of the RT profession, competitors, and cost-benefit rationales. The researcher designed facility demographic questions relating to primary facility type, primary level of care, age group served, bed size, facility funding sources, facility billing, and being CMS regulated. In addition, respondent demographic questions addressed job title, gender, age group, and race.

Data collection procedures were influenced by principles outlined by Dillman (2000) to maximize the potential for an appropriate response rate. The web-based survey was implemented through an online surveying tool, *SurveyMonkey*. Mailed surveys were manually entered into the *SurveyMonkey* database. Data were exported from *SurveyMonkey* into Microsoft Excel files, which was transferred into the Statistical

Package for the Social Sciences© version 18.0 for data analysis. Five treatment services were evaluated in this study: activity services, occupational therapy, physical therapy, speech therapy and RT. In comparison to the other treatment services, RT received the lowest responses for service benefit, service familiarity, being a usual part of the interdisciplinary team and utilized service. All treatment services exhibited some level of competition toward RT with activity professionals identified as the largest competitors for LRTs. Respondents perceived activity professionals having the most overlap with LRTs and the least amount of difficulty to perform a LRTs job. Other barriers to having a LRT on staff were related to budget and a perceived lack of need for services at facility. Conclusions and implications of this study are included, as well as recommendations for future research and practice.

ADMINISTRATIVE PERSPECTIVES OF RECREATIONAL THERAPY SERVICES IN NORTH CAROLINA

By

Laura E. Harkins

A Thesis Submitted to
the Faculty of the Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Master of Science

Greensboro
2010

Approved by

_____

Committee Chair

To Mom and Dad

My loving parents who taught me the meaning of hard work and commitment

APPROVAL PAGE

This thesis has been approved by the following committee of the Faculty of The Graduate School of The University of North Carolina at Greensboro.

Committee Chair _____

Committee Members _____

_____

_____
Date of Acceptance by Committee

_____
Date of Final Oral Examination

ACKNOWLEDGMENTS

The success of this thesis was made possible through the combined support of those individuals and groups that took an interest in enhancing my professional developments and helping transform my idea into a reality.

First and foremost, I would like to thank Dr. Leandra A. Bedini for her remarkable dedication, endless support, and encouragement throughout this entire process. As my committee chair and advisor, Dr. Bedini became a mentor to me providing the necessary tools for me to be successful in this journey. She is also a wonderful friend, who provided much needed comic relief and reassurance whenever I felt overwhelmed.

I would also like to thank my other committee members for their constant support and patience. Dr. Linda Buettner's tremendous insight and research experience was invaluable. Even more so, her commitment to the recreational therapy profession is truly inspiring. Dr. Bonnie Canziani's knowledge of concept mapping, surveys and data analysis were instrumental in improving my research skills and capabilities. I feel blessed to have had the opportunity to work with both of you on a professional level and look forward to being colleagues as I start my career.

A special thanks to Becky Garrett, the Executive Director of the North Carolina Board of Recreational Therapy Licensure. Her expertise of the professional advancement of the recreational profession made significant contributions to this study.

Thank you to Peg Connolly, Ray West, Pam Wilson, Lisa Morgan, Missy Armstrong, and Karen Luken. Despite their busy schedules, they managed to make time to contribute advice and feedback on survey development and data collection techniques.

Acknowledgement must also be given to the Therapeutic Recreation Division of the North Carolina Recreation and Parks Association. Their financial contributions to this thesis prove their commitment to the growth and development of the profession.

I would also like to recognize my close friends Ashtyn Kemper and Angie Sardina for managing to keep me grounded throughout my graduate experience. Their tolerance of listening to every boring detail of this study was much appreciated.

I am extremely grateful for my family who never doubted my professional endeavors. Thank you, Mom and Dad for believing in me and being such proud, loving parents. I attribute my accomplishments to your encouragement and support. A special thanks to my big brother, Joseph, whom I have always looked up to in academia.

Finally, I would like to thank my best friend and significant other, Patrick, for motivating me to best the person I can be and inspiring me to pursue an advanced degree. His love, support, and encouragement was unwavering. I love you.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF TABLES (Continued)

CHAPTER I

INTRODUCTION

Problem Statement

In recent years, recreational therapy (RT), often referred to as therapeutic recreation, has made significant professional advancements. For example, RT has gained state licensure within four states as well as being recognized as part of the Minimum Data Set (MDS). However, many factors and trends seem to be impacting the image and status of the RT field. RT has been struggling for a long while to gain proper recognition and respect within health care communities. Lack of recognition is evidenced by the paucity of educational resources informing interdisciplinary members (i.e., doctors, nurses) about RT services (Edward, 1998). Moreover, Hinton (2000) identified RT as being absent from allied health career books and General Social Surveys ranking prestige among professions. The Department of Labor's Occupational Outlook Handbook (OOH) 2010-2011 showed that there are fewer jobs and lower salaries in the RT field compared to the fields of occupational, physical, or speech therapies. In addition, RT's identity is confused with other therapies as some health care facilities assume they provide RT; however, in reality, it is other professionals such as activity professionals, occupational therapists, and physical therapists who provide recreation-based activities. RT has been noticeably absent in many health care settings in which consumers could greatly benefit (Nation, Benshoff, & Malkin, 1996). These professional trends are widely recognized and

have merited further research. However, literature searches have revealed little, if any, previous research investigating health care administrators' perspectives regarding why their facilities do or do not offer RT services.

Purpose Statement

The purpose of this study was to survey key supervisory staff at North Carolina health care facilities to (a) identify the existence and positions that compete with recreational therapy (RT) services, and (b) understand the rationale driving health care facility decisions related to the provision of RT programs to their clients.

Research Questions

Thus far, no research has investigated administrators' perspectives of RT services in health care facilities directly. For this study, the researcher developed five research questions based on Social Marketing Theory (Morris & Clarkson, 2009) which is further discussed in Chapter Two. The goal of this study was to answer the following research questions:

1. What are the determinants of hiring recreational therapy professionals within health care facilities in North Carolina?
2. What types of facilities hire or do not hire recreational therapists?
3. How does perceived occupational prestige of recreational therapy impact the hiring decision?
4. What is the perceived prestige of the recreational therapy occupation compared to the perceived prestige levels of competitor professions?

5. What are the perceived benefits and barriers that contribute to estimated occupational value of recreational therapy practitioners to health care facilities?

Definition of Terms

The following terms are defined to clarify their use in the study:

Activity services: It is the responsibility of the activity professional to implement, supervise, and evaluate all activity programming designed for the clients/residents personal interest and personal choice to include: physical, cognitive, social, spiritual, and recreational activities (National Association of Activity Professionals, 2007).

Alternative medicine/therapy: A group of diverse medical and health care systems, practices, and products that are not generally considered to be part of conventional medicine (National Center for Complementary and Alternative Medicine, 2010)

Assisted Living: Housing or living arrangements for the elderly, infirm, or disabled, in which housekeeping, meals, medical care, and other assistance is available to residents as needed (The American Heritage Dictionary, 2010)

Continuing Care Retirement Community: A particular type of retirement community that offers several levels of health care on one campus: independent living, assisted living, memory care, skilled nursing, and rehab (Pacific Retirement Services, Inc., 2010)

Occupational prestige: The [perceived] social standing or status of an occupation (Zhou, 2005)

Occupational therapy: The therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home,

school, workplace, community, and other settings (The American Occupational Therapy Association, 2009).

Physical therapy: Use treatment techniques to promote the ability to move, reduce pain, restore function, prevent disability and prevent loss of mobility by developing fitness- and wellness-oriented programs to help you achieve a healthier and more active lifestyle **(**Move Forward Physical Therapy, 2007).

Recreational therapy: Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's orders must include the frequency, duration and scope of treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant (CMS, 2006).

Speech therapy: Therapy that evaluates, diagnoses and treats speech, language, cognitive-communication and swallowing disorders in individuals of all ages, from infants to the elderly (American Speech-Language-Hearing Association, 2009).

Delimitations

There were two delimitations of this study. First, in order to represent persons who typically have influence on hiring decisions, only persons in supervisory positions (e.g., CEO's, Vice Presidents, Administrators) were invited to participate in the web-based survey. It was not the researcher's intent to obtain data from the client community, Licensed Recreation Therapists (LRTs), or other allied health professionals. Therefore, data related to inter-occupational perceptions and LRTs self-image were not collected. The other delimitation was that the researcher did not include all health care services

listed on the Department of Health and Human Services database. The cardiac, surgical, and home health care agencies were eliminated because these settings are not prevalent to RT. In order to keep the sample consistent, all community-based settings were also eliminated. Therefore, the mental health sample was drastically reduced after removing irrelevant facilities labeled as alternative family living, supervised living of adults with developmental disabilities and adult developmental vocational programs.

Significance of the Study

This study introduces a new line of research which will advance the body of knowledge of the RT profession. It has the potential to educate RT practitioners on administrators' points of view of what RT services entail, to identify competitors to RT, and to explain why LRTs are included or not included within health care facilities' staffs. Obtaining and interpreting administrators' perceptions about RT are vital to developing future strategies for marketing the RT profession to healthcare facilities and to their clients.

Thorn (1984) recommended the following target markets for RT: clients, referral sources, third party payers and hospitals/communities (p. 43). Unfortunately, over 25 years later, the amount of research inquiring about RT perspectives of these varying populations is minimal. The few studies (Edward, 1998; Hinton, 2000; Smith, Perry, Neumayer, Potter, & Smeal, 1992) that do exist are dated and have found that other health care professions display negative perceptions and occupational prejudice towards RT. Edward (1998) was the only researcher identified in this study who gathered data on why negative attitudes toward RT exist. In her study, a follow-up interview process was

employed to probe more deeply into such reasons and found that RT was not part of other health care professionals' professional curriculum. Hinton (2000) identified inconsistencies in explaining why occupational prejudice toward RT existed and Smith and colleagues (1992) did not determine why there were differentiating perspectives between recreational and occupational therapists.

Overall, this study has great potential to improve strategies for marketing the RT field. Understanding health care administrators' perceptions about RT can help the profession (a) determine which attributes people associate with RT and (b) find out what administrators' fail to acknowledge about RT that might be important to RT's reputation as a healthcare profession. Specifically, this research aims to explore hypothetical relationships between healthcare administrators' perceptions of RT and having a LRT on staff. Administrators often have influence on decisions to offer specific types of treatment services to their client base and subsequently their input is invaluable. Therefore, this study is significant in determining deficits in the profession to generate future marketing initiatives.

CHAPTER II

LITERATURE REVIEW

The purpose of this study was to survey key supervisory staff at North Carolina health care facilities to (a) identify the existence and positions that compete with recreational therapy (RT) services, and (b) understand the rationale driving health care facility decisions related to the provision of RT programs to their clients. This chapter will review RT research, including topics such as marketing, licensure, and cost-effectiveness. In addition, specific sections outline comparative benefits of competing health professions and the topic of occupational prestige.

The Public Need for Recreational Therapy

The United States healthcare system is currently under major transition. Many Americans' financial and health status have been several compromised due to the economic recession and the staggering increase in major health conditions, such as obesity and disabilities (Centers for Disease Control and Prevention, 2009). In addition, the ongoing war overseas is resulting in wounded military service members in need of various health care services. In Healthy People 2020, the U.S. government has outlined specific objectives focusing on health and wellness: adolescent health, disability and secondary conditions, hearing/sensory/communication disorders, heart disease and stroke, mental health disorders, older adults, physical activity and fitness, quality of life and wellbeing, and substance abuse (U.S. Department of Health and Human Services, 2010).

With such a strong focus on improved quality of life and the prevention and treatment of disabilities, the call of action to recreational therapists is obvious. In addition, one of the most common practice models upon which recreational therapists provide services is the Disease Prevention and Health Promotion Model (Austin, 2009). Austin (2009) asserted that through this model, recreational therapists "assist clients in both their quests for health protection (overcoming illness) and health promotion (the achievement of the highest level of wellness possible)" (p. 165). In summary, the health and wellness initiatives set forth by the government maintain the importance of RT.

More than ever, recreational therapists have a consumer base that desperately needs their services; however, the true accessibility of recreational therapy services to the general public are questionable in comparison to more established therapies, such as occupational, speech and physical therapies. For example, in May 2008, there were approximately 23,300 recreational therapy jobs compared to 104,500 in occupational therapy, 185,500 in physical therapy, and 119,300 in speech-language pathology (Department of Labor's Occupational Outlook Handbook, 2010-2011). These specific therapies have approximately 4.5 to 8 times more jobs than recreational therapists. The work settings in which occupational, speech, and physical therapists are employed are also where recreational therapy services can be utilized. In fact, the interdisciplinary team should involve all of these professionals; however, as the numbers reveal this is not occurring.

Recreational Therapy: A Unique Service with Endless Benefits

Recreation therapists treat individuals with varying disabilities and function levels. Contrary to traditional therapies, where medicine and standardized instruments are common treatment methods, RT utilizes recreation and leisure as tools to obtain individual client goals and produce positive therapeutic outcomes. This unique treatment method is known for improving the client's quality of life. The World Health Organization (1999) defined quality of life as "an individual's perception of their position in life…[that incorporates] the person's physical health, psychological state, level of independence, social relationships, personal beliefs, and their relation to salient features of the environment" (p. 3). As RT embraces all aspects of the individual's life, specifically working within the physical, emotional, spiritual, social, cognitive, and spiritual domains, improved quality of life is central to the purpose of RT. Hemingway (1987) alluded to the important societal purpose that recreational therapists serve:

> Therapeutic recreation serves those who are in one fashion or another unable to take full enjoyment in the distribution of society's benefits and obligations. This function is performed by removing or reducing the disadvantage so full enjoyment can and does become possible (p. 12)

Moreover, RT provides recreation opportunities for those who would otherwise not fully experience or pursue leisure or recreation avenues due to an illness or disability.

Studies have revealed that RT has proven benefits that are notable to all functional levels including those individuals with physical impairments and disabilities that are prevalent in hospital settings, such as spinal cord injuries and strokes. Hutchinson, Loy, Kleiber, and Datillo (2003) investigated the power of leisure as a

therapeutic intervention in a sample of people with spinal cord injuries. Results showed that "leisure acted not only as a buffer against immediate stressors, but also as a source of motivation to sustain coping efforts by offering hope/optimism and sense of purpose and belonging" (p. 149). In addition, Williams and colleagues (2007) established the importance of RT in stroke recovery, where he found improvements in stroke patients' "functional independence and in gross and fine motor skills" (p. 4). Likewise, Distasio (2008) recognized the importance of RT to patients with allegedly diagnosed incurable diseases. Results from her study showed the positive implications of yoga incorporated as a relaxation technique to recently diagnosed cancer patients with improvements found in "psychosocial measurements (mood, quality of life, and stress) and physical measurements (resting heart rate and cardiovascular endurance)" (p. 126).

Along with physical benefits, RT also produces cognitive benefits. ATRA's former website enumerated the benefits of RT. Citing a 1991 study (i.e., Coyle, Kinney, Riley & Shank), it stated that therapeutic activities positively impacted cognitively impaired older adults with results showing "significantly increased alertness and awareness of their surroundings; reduced confusion and disorientation; improved memory, attention span, and problem solving skills; and reduced reliance upon medication" (T. Ignatiev (ATRA), personal communication, October 1, 2009). Another study by Buettner and Ferrario (1998) introduced RT activities to a number of residents with dementia and the results indicated improvements in "mental/cognitive status, level of depression, right and left grip strength, flexibility and levels of agitated behavior" (p.

5). Overall, the increase in cognition levels is notable because as a person's functional status evolves, they can start improving in other areas as well.

RT also assists individuals with mental illnesses. Rudnick (2005) completed a case study on a 26 year old male who was diagnosed with schizophrenia at the age of 20 and felt hopeless when previous interventions and therapies were inefficient. The following results were recorded after being assigned a recreation therapist due to complaints of boredom:

> …increased sense of self-confidence, more interest and satisfaction in life, and less anxiety so that he started leaving home for a few minutes daily, started playing basketball in the neighborhood and went ice skating with his brother, which he had not done for some years (Rudnick, 2005, p. 65).

In addition, Rudnick (2005) identified the associated benefits of leisure and recreational activities with individuals experiencing any mental illness stating RT "facilitates normalization and socialization, it enjoyably fills the large amount of spare time many people with serious mental illnesses have, it helps cope with symptoms and adverse effects" (p. 65). Animal-assisted therapy is a RT intervention that has proven to have positive results for individuals with mental illness. Barker and Dawson (1998) stated that "animal-assisted therapy was associated with reduced state anxiety levels for hospitalized patients with a variety of psychiatric diagnoses, specifically psychotic disorders, mood disorders, and other disorders" (p. 797).

RT also provides multiple interventions that educate clients on triggers, symptoms, and preventive techniques, such as leisure education and healthy lifestyle groups. Carruthers, Hood and Parr (2005) reiterated the importance of leisure education

within the community stating that "medical professionals attempt to treat diseases and conditions, many of which are created by unhealthy lifestyles…through leisure education, people acquire the attitudes, knowledge and skills necessary to create optimal, enjoyable leisure experiences for themselves" (p. 30). Leisure education ultimately assists in preventing relapse (e.g., depression, isolation, alcoholism). RT also reaches out to families who are enduring transitions by providing a positive outlet and setting where they can learn and grow together. This is supported by Doyle, Wolchik, Dawson, and Sandler (2003) who found "positive events including leisure activities buffered the impact of negative events on adjustment based on both mothers' and children's reports" (p. 543).

RT can take on a major role or supportive role within the treatment plan depending on the client's needs. Even if the major treatment goals are determined by the physical or occupational therapist, recreational therapists can assist in carrying out these goals. Hemingway (1987) distinguished this by stating the reason for TR assistance in some cases "might be that the person's condition is such that only in a specialized setting can that person recreate. Or it might be that the person is undergoing some form of therapy which recreation can enhance" (p. 12). Regardless the role, RT can make a positive impact and assist in reaching the client's optimal health.

Evidenced-based practice (EBP) is an emerging professional trend within health care. EBP ensures the interventions and care provided to consumers is not solely based on what practice traditionally has entailed, but is based on current research that proves what the recreation therapist is doing is both competent and effective. Research proving

the benefits of RT exists, as mentioned above in this section. However, only one literature piece exists that outline clinical guidelines for RT, entitled "Recreational Therapy for the Treatment of Depression in Older Adults: A Clinical Practice Guideline" (Buettner et al., 2008). Austin (2009) identified the lack of EBP within RT starts at the education level and asserted EBP "must be a central feature of the curriculum" (p. 181), where students are learning the steps involved to perform EBP. In addition, Austin (2009) stated RT performing EBP is essential to "keep pace with colleagues in medicine, nursing, and other allied health fields- who are leading the way in implementation of evidence-based practice" (p. 181). Therefore, the existence of EBP within RT is essential for optimal client care, but also to gain equal professional recognition with other health care professions.

Occupational Prestige

Scholars have attributed many factors to the concept of occupational prestige. Rosoff and Leone (1991) identified the best predictors of prestige as high pay and high social value, where "the occupations most valued are those which have the greatest importance to society and require the greatest training or talent" (p. 322). In comparison, Zhou (2005) also found a positive significant association with (a) income and prestige and (b) knowledge/education and prestige. Due to findings of prejudice and negative perceptions toward RT (Hinton, 2000; Smith et al., 1992), it might be assumed that the importance to society and education associated with RT is not high. Moreover, society may view RT as not being medically necessary treatment for clients, while medical recognition has been consistently identified with high prestige (Rosoff & Leone, 1991;

Shortell, 1974). Buettner (2001) explained that RT is considered medically necessary when ordered. However, the extent to which RT services are ordered is most likely perceived to be low due to reimbursement issues and cheaper activity professionals being mandated service. Likewise, graduate level education is not often sought after by RT, where 72% of the CTRSs who participated in the NCTRC profile study (2009) identified their highest level of education as baccalaureate, which included a recreation-based degree rather than a medical degree. Public familiarity of the profession was also identified as leading to a better social standing, although not as highly relatable as pay and social value (Rosoff & Leone, 1991). Previous studies identifying RT not being represented within allied health textbooks (Hinton, 2000) and facilities not having RT that could greatly benefit (Nation, Benshoff & Malkin ,1996) indicate the lack of public familiarity with RT and the poor marketing efforts by the RT profession.

Shortell (1974) investigated prestige differences within medical and allied health professions. The basis of prestige was related to the specialist-patient relationship, in which Shortell (1974) identified that prestige decreases as the patient moves down the following continuum: passive recipient, co-operator, and active participant. The research sample included over 100 physicians, hospitalized patients, and graduate business school students. Physicians were asked to rate the prestige of 41 professionals according to how they believed the public perceived them, while patients and students were asked to identify how physicians would rank the same 41 professions. Results showed all three groups identified patients had a more passive role with medical professionals and that patients took more of an active role within allied health professional treatment.

Consequently, a higher prestige was exhibited within the medical professions. Interestingly, according to one of the most salient RT practice models, the Leisure Ability Model (Stumbo & Peterson, 2004), the role of the recreational therapist should transition from initially a therapist role with much client interaction into a supervisory role with the goal of the client to function independently. Therefore, it would be difficult to measure prestige based on the patient role related to RT because it progress from an active to passive role.

Falk-Kessler and Ruopp (1993) investigated the prestige of occupational therapy in mental health compared to other members of the psychiatric team (i.e., nurses, psychiatrists, psychologists, recreational therapists, and social workers). The researchers studied 154 team members who rated each profession's prestige on a 5 point scale (1= excellent, 5=poor) and ranked the order of the professions on a 6 point scale (1= most prestigious, 6= least prestigious). Recreational therapists' questionnaires were excluded from analysis because only four recreational therapists participated. Results showed recreational therapists received the lowest prestige rating (*M*= 3.21) from the psychiatric team members and were consistently ranked the least prestigious (*M*= 5.77) team member. Occupational therapists were predominantly rated and ranked fifth among team members. Rationale for such low scores for occupational therapists was attributed to prestige being "related to the degree of control over patient outcomes," in which in which the researchers felt OT was at a disadvantage because of the emphasis of "purposeful activity"; moreover, such techniques may be devalued or viewed as simplistic compared to psychologists' use of standardized instruments (pp. 63, 64). The researcher failed to

make that same connection with reasons for recreational therapists' low prestige scores. Dixon's Therapeutic Recreation Directory website, (http://www.recreationtherapy.com) includes a list of definitions, in which Frye & Peters (1972), Iso-Ahola (1980), and Austin (1982) all refer to recreational therapy as the use of "purposeful activity." Based on Falk-Kessler and Ruopp's (1993) findings of low prestige associated with a profession who provides activities as opposed to using more standardized methods, it can be assumed that RT would also be viewed with low prestige in comparison to the psychiatric team.

In addition, Faulk-Kessler and Ruopp (1993) found that professionals who perceive themselves as less prestigious than their cohorts may be affected by poor self-image and low job satisfaction. RT literature supporting this notion is conflicting. Moreover, Smith and colleagues (1992) research indicated that RTs had lower self-image than OT viewed of RT, while the NCTRTC profile study (2009) showed 90% of CTRSs are either very or somewhat satisfied with their job. Therefore, it is difficult to define the prestige of RT through such inconsistencies as both show potential for RT to have either low or high occupational prestige based on self-image and job satisfaction.

Barnett (1975) investigated sex differences and age trends among occupational preference and prestige. The *Harvard Business Review* distributed a survey to 2, 519 young men and women between 9 to 17 years of age. The participants were instructed to pick the top two preferred jobs to enter (indicating preference) and top two jobs they do not prefer to enter (indicating aversion) out of 24 professions. Results showed "the relationships between preference and prestige were positive and stronger for the males

than for the females; those between aversion and prestige were positive and stronger for females than for males" (Barnett, 1975, p. 35). Although this research is outdated, remnants of finding of women tending to avert prestigious professions may still have negative implications on the status of RT because 86% of Certified Therapeutic Recreation Specialists (CTRSs) are women (National Council for Therapeutic Recreation Certification (NCTRC), 2009).

In one empirical study, Zhou (2005) examined past patterns of occupational prestige specifically reported in the 1989 General Social Survey module designed by Nakao and Treas. Zhou (2005) examined the effects of covariates related to his theoretical position on prestige, in which results showed salience in authority positions and salience in knowledge/education as the most significant and positive association with prestige. Moreover, Zhou (2005) reported "raters in high-status occupations or with higher education levels give considerably higher scores to those professions that are salient in authority positions" (p. 121). Given that a future career path for RT is identified as an Activity Director (Payscale Research Center, 2010), RT may have a more prestigious outlook on the basis of maintaining an authoritative position supervising that department. At the same time, there is usually an administrator or clinical supervisor above RT and other health care service professionals.

Interprofessional Perceptions and Prejudice

Interdisciplinary treatment ensures quality of patient care and often includes a team of doctors, nurses, social workers and ancillary services (e.g., occupational therapists, activity professionals, physical therapists, speech pathologists, recreational

therapists). The typical treatment team is comprised of varying levels of occupational prestige. Moreover, doctors are well established as prestigious health care providers and are frequently viewed at the top of the health care continuum (Rosoff & Leone, 1991; Shortell, 1974), while ancillary services struggle within themselves for equal recognition at the bottom (Falk-Kessler & Ruopp, 1993; Hinton, 2000). In addition, Furnham, Pendleton, and Manicom (1981) rationalized occupational perceptions exist between "emerging professionals [and] the older more established professions" (p. 290).

In the last two decades, the researcher found three studies that analyzed interprofessional perceptions or prejudice relating to RT specifically: Edward, 1998; Hinton, 2000; Smith et al., 1992. First, Smith and colleagues (1992) studied interprofessional perceptions between recreational therapists and occupational therapists. A total of 75 Recreational Therapists (RTs) and 80 Occupational Therapists (OTs) completed surveys to reveal significant differences in perceptions between both their own field and the other field. Eighty-five percent of RTs reported OTs had higher status while only 2% of OTs felt RT had higher status. Eighty-nine percent of OTs felt RTs trust their professional judgment compared to 59% of RTs felt OTs trust their professional judgment. Ninety-six percent of RTs felt OTs were well trained compared to 68% of OTs felt RTs were well trained. Eighty-three percent of RTs felt they understood capabilities of OTs, although 40% of OTs felt they understood RTs capabilities. Seventy percent of OTs felt RTs intrude their territory while 37% of RTs agree OTs sometimes intrude. Conversely, 45% of OTs felt RTs intrude their territory while 80% of RTs felt OTs intrude. Thus, significant differences in perceptions truly exist within both fields and

even more so, RTs personally identified inferiority to OTs. Although the study revealed there are significant differences in perceptions, it does not provide reasons for these perceptions.

Edward (1998) investigated 46 health care workers attitudes toward recreational therapy utilizing a modified version of the Interprofessional Perceptions Scale and a follow-up interview was employed for eight participants. The scale included a 5-point Likert scales ranging from (1) strongly disagree to (5) strongly agree to several statements such as, understanding the role of RT, RT being well trained, respect for RT, status of RT. The participants were grouped by paramedical (social work, chaplaincy, dietary and pharmacy; $n = 11$), physical medicine group (physiotherapy, occupational therapy; $n = 10$, and the medical group (nursing and physicians; $n = 25$). Results showed most items were over 3.0 on the scale and indicated the paramedical group exhibited the most positive attitude toward recreational therapy, while the physical medicine group was ambivalent and the medical group held the least positive attitude. Findings consistently showed that respondents were uncomfortable about discussing the role of RT because they were unsure of training methods and RT was absent from their educational curricula. Overall, Edward's data revealed the medical group of nurses and physicians, which are among the highest regarded interdisciplinary members, required the most education and marketing techniques about RT.

Hinton (2000) investigated occupational prejudice between allied health professionals', more specifically, if occupational prejudice existed toward recreational therapy. Interestingly, Hinton's literature analysis reported that out of a total of 16 books

on allied health careers, recreational therapy was included in only 62% of them, while physical therapy was in 95% and occupational therapy was included in 100% of the texts. In addition, Hinton remarked that out "of the ten books that included recreation therapy only four included comparatively equivalent review" (pp. 25-26). For her study, Hinton utilized a convenience sampling method including conference attendees with a total of 336 participants from seven conferences. This sample included occupational therapists, physical therapists, recreational therapists and nurses. Occupational prejudice was determined two ways: (a) through a mean score ranging from 10 (highly prejudiced) to 70 (not at all prejudiced) and (b) the allocation of money to the health services. First, occupational prejudice was exhibited toward recreational therapists with the most prejudice found in physical therapy with 47, followed by occupational therapy with 50, nursing with 55, and recreational therapists with 63. The second portion of her survey that analyzed occupational prejudice asked the participant to designate how much money they would allocate to each profession (RT, OT, PT), if they only had $100. Note nursing was excluded from this question, but did answer how they would allocate the money within the three services. Results were as follows. PT gave themselves $45.53 and RT $20.55; OT gave themselves $41.16 and RT $22.85; Nursing gave PT $39. 17, OT $31.52, and RT $29.07; RT gave PT $34.59, OT $28.86, and themselves $37.41. In comparison to physical therapy who received a total of $37.87 and occupational therapy with $33.16, recreational therapy received the lowest money of the three with a total average of $29.26. The main reason for occupational prejudice toward recreational therapy was lack of knowledge of education and training. Hinton described a reasoning

for this may be due to the "lack of status for recreation therapy, as training for recreational therapy professionals is still most often a concentration in schools of recreation and leisure studies, rather than in separate, medically oriented programs" (p. 59). Similarly, she reveals that since "recreation therapist have a different (non-medical) education, [they] are ranked lower in the prestige hierarchy and rarely get reimbursement for their services, fun and games stigma may lead to differential status" (p. 72).

Cost-benefit of Recreational Therapy Services

The transitioning health care system forces extreme pressure on the costs of health care services offered to consumers. RT is considered a cost-effective service (e.g., Coyle et al., 1991); Thompson, 2009; Thorn, 1984) primarily because recreational therapists receive a lower average salary than competing allied health professionals (OOH, 2010-2011). The OOH (2010-2011) provided a specific break down of the reported earnings for each of these professionals in May 2008. The median average salary for recreational therapist was $38,370 compared to $62, 930 for speech pathologists, $66,780 for occupational therapists, and $72,790 for physical therapists. The middle 50 percent of recreational therapists earned between $29,660 and $49,140, while the middle 50% of speech pathologists were $50,330 and $79,620, occupational therapists receiving $55,090 and $81,290, and physical therapists between $60,300 and $85,540. The lowest 10% of recreational therapists received less than $23,150, compared to speech pathologists at $41,240, occupational therapists at $42,820, and physical therapists at $50,350. Finally, the highest 10% of recreational therapists earned more than $60,280, speech pathologists $99,220, occupational therapists $98, 310, and physical therapists at $104, 350. Even the

highest 10% of recreational therapy salaries are lower than the average salaries of the allied health professional. Nursing care facilities were identified as the "largest industry employing recreational therapists" and is predicted to keep increasing as the baby boomers age (OOH, 2010-2011). The average salary received by recreational therapists in nursing care facilities was $33,920. The differences in salaries may be attributed to the varying degree requirements. The OOH (2010-2011) revealed that a baccalaureate degree is the minimum requirement for RT while most occupational, speech, and physical therapy positions require post-baccalaureate degrees to practice.

Although recreational therapists dislike receiving lower salaries than their counterparts, Thompson (2009) advised that "under a capitated reimbursement system, it's a significant marketing advantage" (p. 308). Moreover, "the inclusion of recreational therapy services further expands the available pool of qualified rehab personnel to respond to the needs of the health care consumer at a reasonable cost" (T. Ignatiev (ATRA), personal communication, October 1, 2009). In addition, RT is unique because it provides group treatment, which allows clients with identical goals to be treated simultaneously at the same salary expense (Coyle et al., 1991). Despite identified cost-effectiveness of RT, the OOH (2010-2011) predicted RT will continue to experience job competition with lower paid recreation aides to perform relevant job tasks at a lower cost.

Recreational Therapy versus Activity Services

RT and activity services are complementary when utilized appropriately within many health care settings. Unfortunately, the competitiveness between the professions inhibits interdisciplinary teamwork. Interestingly, according to the Payscale Research

Center (2010), Activity Directors are a future career path of RTs to consider, but there are identifiable differences within the professions. Activity services are federally mandated and routinely offered to clients, while RT is medically prescribed or necessary when ordered by a health care professional (Buettner, 2001).

The inability for activity professionals, recreational therapists, and other health care professionals to differentiate between the two disciplines exhibits the lack of education among all health care professions. Confusion may be attributed to the varying positions that meet requirements to become activity directors. Specifically, the Center for Medicare and Medicaid Services (CMS) (2006) outlines specific guidelines for the requirements of an individual upholding the activity director position. CMS (2006) stated that the activity director must be a "qualified professional" who is ***either*** (a) a qualified therapeutic recreation specialist, (b) a licensed or registered activity professional, (c) with two years recent experience in a recreational program, (d) a qualified occupational therapist or occupational therapist assistant, ***or*** (e) has completed a State approved training course (http://www.cms.hhs.gov). Pursuing licensure and/or certification for recreation therapy includes a four year college degree, completion of 480 hours at an approved internship site, specific course requirements, and passing of a national certification exam *or* a minimum of 1500 hours working full-time and passing of the national certification exam (National Council for Therapeutic Recreation Certification, 2009). On the contrary, activity certification is obtained through various tracks with a minimum requirement of a high school diploma, 90 hour modular education program for activity professionals, and 2,000 hours of experience within the past five years (National

Certification Council for Activity Professionals, 2010). In one research study, Legg, Nazaruch, & Adelman (2010) identified a lack of knowledge at the administrative level, in which "nearly 27 percent of skilled nursing facilities in the sample did not employ an individual who met [the CMS requirements listed above] for an activity director" (p. 11). This is a concerning statement, as the requirements for activity directors are not demanding or limiting in any fashion. Also, administration not fully understanding the role of RT versus activities is not a new concept. In 1978, Cozart and Evashwick published on the emerging issues of the integration of RTs within nursing homes, but reported administrators lacked the resources and knowledge to suddenly change patient care practices based on RT. Also, Uniack (2005), a health care administrator, published a book as a useful desk reference for activity programs in SNFs. The cover of the book is directed toward activity professionals and recreational therapists alike, but never distinguishes between the roles within the text.

In addition, Corbett (1998), a CTRS who published a book relating to senior activity services, wrote one chapter entitled, "Therapeutic Recreation in Long-Term Care;" however, not once does she mention her own credential, CTRS and the additions or professionalism it can bring to the activity department. Instead, Corbett (1998) defined RT, as the "the use of leisure time and leisure pursuits as a form of treatment," but immediately made the connection back to activities; "in the nursing home, the activity services department makes use of residents' time not spent in activities of daily living" and established the appropriateness of the word "therapy" with the activity professional

(p. 13). Publications such as these provide evidence that lack of knowledge exists within the RT profession as well.

In response to the addition of RT to the Minimum Data Set (MDS), Selman and Land (1998) published an article advising skilled nursing facilities (SNFs) to stop replacing Certified Activity Directors with CTRSs. Selman and Land's (1998) main arguments were (a) that RT was not deemed appropriate for long-term care facilities and functions better within rehabilitation settings and (b) RT was a non-reimbursable therapy. The author's recommendation for owner's to choose between an activity professional and a CTRS based on care setting is illogical, especially within SNFs. CTRSs treat clients in all health care settings alike. The authors are no considering the benefit and logic of combining professionals to maximize cost-benefit.

Nation, Benshoff and Malkin (1996) investigated the existence and focus of therapeutic recreation programs within substance abuse settings. The researchers sent questionnaires to the activity therapist of 250 substance abuse treatment facilities identified by the 1992 National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs. Results revealed that about half (49%) of the facilities did not have RT programs. Primary inhibitors to providing RT services included shortage of staff to implement programs (68%) and shortage of funding for recreational services (60%) (Nation et al., 1996, p. 12). In addition, 77.9% of the facilities RT programs were conducted by activity professionals. This last finding may be linked to the first in that because so many facilities lacked proper funding resources, most RT programs were being implemented "illegally" by cheaper activity staff.

Marketing

The national professional organizations, American Therapeutic Recreation Association (ATRA) and National Therapeutic Recreation Society (NTRS), and credentialing body, National Council for Therapeutic Recreation Certification (NCTRC), have been the primary advocates for recreational therapy for decades. ATRA developed a marketing team and brochures for the field. Similarly, in 1994, NTRS published the *Promoting Therapeutic Recreation: The Marketing Guide.* The NCTRC has also marketed RT through brochures. In 2004, NCTRC created "Why Hire a CTRS" and "Why Become a CTRS" brochures. Unfortunately, these marketing efforts are primarily made up of brochures and a "how-to" guide. While both national and most state RT organizations have a marketing committee, little unified, targeted, and universal marketing of RT is done in the profession. Local and limited efforts will not address the problems identified.

Thorn (1984) was a major contributor to marketing and recreational therapy literature. Interestingly, many of his concerns as well as concepts are still prevalent today. He stressed the importance of identifying recreational therapists' professional image, specifically determining attitudes toward the profession and its services. Thorn (1984) advised the field to "research the hospital and community's perceptions to sort out the discrepancies between the desired image and the actual image" (p. 44). Twenty-five years later, this information has yet to be extensively obtained especially at the administrator level. This gap needs to be closed by disseminating information and advocating for RT profession. It is the researcher's intention to obtain the "actual image" Thorn (1984)

refers to by utilizing the Social Marketing Theory as the theoretical foundation of this study.

Theoretical Framework

The present study was conceptually grounded on the Social Marketing Theory (Morris & Clarkson, 2009). Specific research questions were derived from the theory and the following supporting principles: (a) goals for the target market behavior, (b) insight into customer decision processes, (c) segmentation and targeting, (d) competition, (e) exchange, and (f) marketing and intervention mix. The following paragraphs will describe these principles in detail. In every case, the target market in this study is assumed to be healthcare administrators who might be involved in hiring RT professionals.

Behavior goals are the first principle of the theory and address "changes in knowledge and attitudes…as they lead to actual behavioral changes" (Morris & Clarkson, 2009, p. 137). The researcher was particularly interested in identifying the knowledge and attitude toward recreational therapy services from administrative figures within various health care facilities. Previous studies revealed that inter-occupational and occupational prejudice exists toward recreational therapy (Hinton, 2000; Smith et al., 1992). Based on these findings and the profession's struggle for respect and recognition, it is assumed that many administrative professionals either do not know about or possess negative attitudes and misconceptions toward recreational therapy services. In order to see positive behavioral changes toward recreational therapy services, the knowledge and attitude of key administrative figures must be obtained and evaluated. Morris and

Clarkson (2009) established that "knowing what needs to change to enable new behavior depends on developing customer insight" (p. 137).

Customer insight is "understanding why people do what they do, why it benefits them, who and what influences them, and what, if anything, stops them" (p.137). For the purposes of this study, the researcher is interested in obtaining the insight, more specifically the administrative perspective, of potential competitors to RT and perceived benefits and barriers of RT in their respective agencies. Such items will better determine the proper approach for segmentation and targeting.

The segmentation and targeting principle inspired one of the research questions that this study aimed to address, specifically, which demographics to target in the future. It is expected that not all administrators perceive RT in the same way; therefore, market segmentation can assist in determining how to market RT appropriately to match the different needs and perspectives of individual administrators.

The competition aspect of the Social Marketing Theory is crucial because it identifies who or what stands in the way of achieving the behavioral goal of having healthcare administrators value and hire RT professionals. Morris and Clarkson (2009) defined the competition principle as "all the factors that compete for people's attention, willingness or ability to change" (p. 137). Competition is obvious to the recreational therapy professionals. There is a constant struggle for an identity that is separate from activity professionals and an ultimate goal to achieve the same respect and recognition as other allied health professions, such as physical, speech, and occupational therapies.

More information is needed to identify what benefits and barriers administrators acknowledge to set up the best exchange possible.

The fifth principle, exchange, is involved in many marketing theories because it essentially implies exchanging money for a product or service. There will not be a behavioral change without an attractive exchange that the customer (in this case the healthcare administrator) finds beneficial. Morris and Clarkson (2009) ascertained that "tangible, certain, immediate and direct benefits tend to be more attractive, but these are not common in healthcare" (p. 137). In social marketing exchange is often considered "more complicated, often involving third parties, intangible benefits, and the transfer of values, beliefs, or affect" (Morris & Clarkson, 2009, p. 137). RT is considered a cost-beneficial service (Coyle et al. (1991); Thompson, 2009; Thorne, 1984); however, there are identifiable concern areas, such as reimbursement issues and lack of evidence based interventions to support treatment modalities. Through this survey, the administrators identified to what degree they found RT as a cost-beneficial option. This information is valuable because, as Morris and Clarkson stated, "the cost can include financial, emotional, social, loss of preferred behaviors, and time cost of learning new practices" (2009, pp. 137-138).

The final principle of the Social Marketing Theory is the marketing and intervention mix. The infamous four P's of marketing come into play: product, price, place, and promotion (Morris & Clarkson, 2009). Bright (2000) stated that the "four p's" of social marketing must be "consistent with the audiences wants and needs…is accessible to the target audience…the benefits to [the audience] are worth the costs they

would incur [and] is designed and conducted in ways that are appropriate to the target audience's life" (p. 14, 15). All four concepts must be carefully considered when developing future marketing initiatives for the RT profession.

Summary

In summary, U.S. government initiatives support the public need for RT professional services. However, the social accessibility of RT programs is lacking (Nation et al., 1996) and may be attributed to interprofessional perceptions and prejudices toward RT (Edward, 1998; Hinton, 2000; Smith et al., 1992). Although literature discusses different viewpoints of RTs and Activity Professionals, there has not been a study that determined the extent of this competition and the implications it may have on the RT profession. Therefore, it is the researcher's intention to utilize Social Marketing Theory principles to gain a better understanding of social perceptions and develop a marketing plan to facilitate the education and knowledge of the RT profession.

Hypotheses

The following hypotheses were constructed by the researcher in relationship to the research questions and literature presented in this chapter:

H^1: Respondents' who represent facilities with LRTs will exhibit higher levels of perceived familiarity than respondents in facilities without LRTs.

H^2: Respondents' self-professed *perceived* familiarity with recreational therapy will not show a significant association with measures of *actual* familiarity with recreational therapy attributes.

H^3: Respondents' who perceive recreational therapy to have a high replacement value [that is, RT duties can be easily fulfilled by non-RT persons], will identify other professionals providing RT within their facilities.

H^4: Occupational prestige ratings for occupational, physical, and speech therapies will be higher than the prestige rating for recreational therapy.

H^5: Those who characterize recreational therapy as an expensive service with little to no benefit will also indicate the following behaviors: (a) not having a LRT at the facility, (b) hiring other professionals to perform RT duties, and/or (c) if they do have a LRT, the LRT will receive a lower salary than those administrators who identified RT as highly beneficial and inexpensive therapy.

CHAPTER III

RESEARCH METHODOLOGY

The purpose of this study was to survey key supervisory staff at North Carolina health care facilities to (a) identify the existence and positions that compete with recreational therapy (RT) services, and (b) understand the rationale driving health care facility decisions related to the provision of RT programs to their clients. This chapter describes the techniques for participant sampling, survey development and implementation, and data analysis used in this study.

Sample

The sampling frame was obtained from the North Carolina Department of Health and Human Services (DHHS) website (http://www.ncdhhs.gov/dhsr/reports.htm). The DHHS website lists all licensed health care facilities in North Carolina. The cardiac, surgical and home health care agencies were excluded from the sample because these settings are not prevalent to RT. The researcher specifically included the remaining facility types: hospitals (*n*= 124); psychiatric hospitals (*n*= 5); nursing homes (*n*= 398); long term care system (facilities with special care; *n*= 156); mental health (*n*= 2159). In order to maintain sample consistency, all community-based settings were eliminated. Therefore, the mental health sample was drastically reduced from 2159 to 763 after removing irrelevant facilities labeled as alternate family living, supervised living of

adults with developmentally disabilities, and adult developmental vocational programs. Total sample size was 1446 facilities.

Data Collection

The Internal Review Board (IRB) of The University of North Carolina at Greensboro granted the researcher formal approval to conduct this study. Data collected was anonymous and confidentially treated. The web-based survey was the most appropriate and convenient research method considering sample size, time and monetary constraints. Moreover, having the survey online saved the researcher time on printing, mailing, and paying postage for hundreds of interested participants. A printed version of the web-based survey was made available for those participants who preferred completing a paper-based survey. However, the survey (See Appendix B) was primarily distributed online. The survey was initially opened at the end of January when the researcher began making phone contacts and was closed in March following shortly after the final reminder emails were sent to the last phone contacts.

Data collection procedures were largely influenced by Dillman (2000) in that specific techniques were used to keep survey errors and non-response at a minimum: contacting participants multiple times, personalizing e-mails, having an alternative response method, attaching the survey to the reminder e-mail, and beginning the survey with a simple item. Targeted facilities on the DHHS database were contacted by phone in alphabetical order of facility name. Each facility received a phone call from the researcher because no email addresses were provided on the DHHS database. The researcher contacted each facility individually by phone; this phone contact served to

notify the respondent of the research and, if interested, that he or she would be receiving the survey soon. Kaplowitz, Hadlock and Levine (2004) found web survey response rates comparable to mailing when preceded by an advance mail notification; the researcher expected an advanced phone call could serve the same purpose, if not better, as the mail notice. The 667 respondents who provided their e-mail address during the initial phone contact received a follow up e-mail with a web link of the survey embedded in the e-mail; a reminder e-mail was sent one week later. The eleven administrators who preferred to receive a paper survey through the mail received the printed-out questionnaire, a personally signed cover letter, a pre-addressed stamped envelope to mail back to the researcher, and a reminder phone call one week later. As the researcher collected e-mail addresses from the nursing home section of the DHHS database, administrators commented they had an e-mail listserv of all North Carolina administrators but were fearful of releasing this information due to privacy concerns. The researcher explained to administrators that obtaining listserv information was not of interest because the initial contact was made by phone. Although Dillman (2000) suggested sending out personalized emails to avoid creating a listserv, since the listserv already existed, the researcher sent out a mass e-mail including the web link to the survey to the first 300 nursing home administrators' email addresses collected. From that point, all contacts who provided their email addresses were immediately emailed the web link to the survey after the phone call to ensure personalization; reminder emails were personalized as well. Finally, both web and paper-based survey participants did not incur financial costs to take part in the study. In fact, a gift card was randomly selected for one participant. In

addition, an executive summary of the results was provided to each respondent indicating interest in receiving one.

Due to the diversity of agency types and of the administrative roles within, various types of supervisory professionals were solicited to participate in this research: Chief Executive Officers, Vice Presidents, Directors of Community Relations, Administrators, Executive Directors, Directors of Marketing and Planning, Clinical Directors, Directors of Rehabilitation Services, and Directors of Behavioral Health. The researcher was interested in contacting supervisory professionals with the highest ranking with exception to owners/operators. When contacting hospitals, the researcher attempted to contact CEOs and Vice Presidents first, but if these administrators were unavailable or uninterested, directors of rehabilitation or behavioral health setting took their place in the study. Persons in the title of *administrator* were contacted at nursing homes and assisted living facilities. Executive and mental health directors were preferred when contacting mental health facilities. In addition, some facilities referred the researcher to marketing or clinical personnel.

Instrument

The survey was developed with the help and consensus of several certified recreational therapy as well as non-recreational therapy professionals. The recreational therapy professionals that provided survey feedback included the current President of ATRA, the Executive Director of the North Carolina Board of Recreational Therapy Licensure, and several RT academic professors, researchers, and practitioners within the state. The non-recreational therapy professionals included a UNCG graduate level

research course and selected Recreation, Tourism and Hospitality department faculty, who received and took the online survey as a method to establish face validity.

The survey consisted of 42 questions that were designed to determine the existence of RT/TR services in the facilities, respondent perceptions of occupational prestige, knowledge and perceptions of the RT/TR field, existence of competitors to RT, and cost-benefit rationales. Specifically, the survey was divided into the following sections: (1) Introduction (IRB Consent Form), (2) Facility and Services, (3) Opinions about Professional Services, (4) Professional Services at Your Facility, (5) Activities, Programs, and Therapies, (6) LRT Inclusive (questions to only those facilities who have a LRT), (7) LRT exclusive (questions to only those facilities who don't have a LRT), and (8) Demographics. Response options were primarily along four or five-point Likert scales either ranging from (1) *strongly agree* to (4) *strongly disagree* or the scale was dependent on the survey item. For example, the survey item addressing respondents' familiarity with treatment services ranged from (1) *extremely familiar* to (5) *not at all familiar*. Most of the survey items included all treatment services to offer a comparison between RT and other health care professions. The survey also included questions that were RT specific to gain a better idea of the participants' opinion of the benefits and barriers that may attribute to the inclusion or exclusion of having a LRT on staff, as well as determine the amount of RT investment (i.e., what is the starting salary for a LRT at your facility, how many LRTs are on staff).

The researcher designed questions that gathered descriptive information about the facility: primary facility type, primary level of care, age group(s) served, number of beds,

primary source(s) of funding, facility billing, and Center for Medicare and Medicaid Services (CMS) regulated. In addition, participants were asked to complete researcher-designed demographic questions that addressed participants' job title, gender, age group, and race. Demographic information created a customer profile of the survey respondents and assisted with data analysis in determining if differences were found between demographics. In addition, the demographic data served as indicators of how to properly segment future marketing efforts for the RT profession.

A review of the relevant literature (Hinton, 2000; National Council for Therapeutic Recreation Certification (NCTRC) profile study, 2009) was fundamental to item construction and development. Facility demographic items (e.g., facility type, level of care, age group served) and associated responses (e.g., hospitals, inpatient) were largely influenced by the NCTRC Profile Study. Survey items regarding perceptions of RT, such as providing fun activities in downtime, were obtained from Hinton's (2000) survey. The survey items were also conceptually grounded from the Social Marketing Theory (SMT) (Morris & Clarkson, 2009) principles: behavioral goals, customer insight, segmentation and targeting, competition, exchange, and marketing. The researcher, with the assistance of a committee member, utilized the SMT principles combined with various literature pieces to create a "mapping" model. This model was used strictly as a guide to create survey items in relationship to the literature and presented research questions.

The researcher also constructed a scale to measure prestige using similar concepts (e.g., high pay, social value) reported by Rosoff and Leone (1991) and principles (e.g.,

legitimacy, differentiation) discussed by Zhou (2005). The following survey items served as respondents' indicators of prestige: medically prescribed, alternative medicine, interdisciplinary team member, service professional cost, recognition of licensure, rigor of education/training, providing recreation-based interventions, and providing clients with fun activities to do in their downtime. The respondents were instructed to select the level of agreement or disagreement with the following variables related to the five treatment services (except recognition of licensure item was only directed toward RT): being medically prescribed, being viewed as an alternative medicine, being part of the interdisciplinary team, cost of hiring the service professional, rigor of education/training, degree to which professional is providing recreation-based interventions, the degree to which professional is providing clients fun activities to do in their downtime, and the requirement of licensure to be able to practice RT. The licensure variable was the only item that did not include all five treatment services. In an attempt to verify these eight items would function as a scale to prestige, the researcher conducted a Cronbach's Alpha reliability test. It is important to note that "alpha scores of 0.8 are a reasonable goal, while any score under 0.5 is an unacceptable score for internal consistency between items" (George & Mallery, 2003, p. 231). Although the literature suggested these items may indicate prestige, the alpha score ($\alpha = 0.4$) did not provide justification for the researcher to assume the 8 items could function as a scale of prestige. Therefore, in the following chapters each prestige item was analyzed independently when entered into statistical analysis.

The survey was implemented through *SurveyMonkey*, an online survey tool that automatically navigates the participant through the survey depending on how they answer items. This was especially effective when separating those survey participants who identified having a LRT and not having a LRT. As such, the respondent would be directed to a set of questions based on how they answered that item. In addition, *SurveyMonkey* allowed the researcher to manually enter the data from the mailed surveys into the online survey database; therefore, *SurveyMonkey* accounted for all mailed and online surveys.

Data Analysis

Although *SurveyMonkey* provided informative descriptive results, data analysis was also completed. Upon closing the survey, the researcher exported data from *SurveyMonkey* into three Microsoft Excel© files. Each survey item was copy-pasted from Excel into the Statistical Package for the Social Sciences© (SPSS) 18 for further data analysis.

Data were primarily quantitative and analyzed using crosstab chi-squares, independent samples *t*- tests, Pearson's product-moment correlations, and analyses of variance (ANOVA). If warranted, post-hoc analyses were also conducted using Tukey's HSD to better determine where significant differences were found. Some variables were collapsed to strengthen data analysis by increasing the n-sizes in certain statistical procedures with no expected change in conceptual value of the variables. Cases with incomplete data were excluded. The researcher set .05 as the default level for significance. The qualitative data analyzed were generated from one open-ended item

asking respondents to share their perspectives about the benefits of having a LRT on staff. These qualitative data were analyzed by both the researcher and her committee chair to ensure inter-rater reliability.

CHAPTER IV

RESULTS

The purpose of this study was to survey key supervisory staff at North Carolina health care facilities to (a) identify the existence and positions that compete with recreational therapy (RT) services, and (b) understand the rationale driving health care facility decisions related to the provision of RT programs to their clients. The results of the web-based survey are reported in this chapter along with a description of the sample and response rate. Relevant results are presented under each research question.

Total Sample Descriptive Results

A total of 678 health care administrators in North Carolina, out of the 1446 total sample, were mailed or emailed the survey. Six of the eleven administrators who preferred the mailing option returned the survey combining for a mail response rate of 54.5%. The remaining 667 respondents received the web-based survey, in which 413 were returned for a response rate of 62%. Altogether a total of 419 surveys were returned giving a response rate of 62%. In addition, as identified by *SurveyMonkey*, a total of 347 (82.8%) were fully completed surveys. Therefore, the response rate for fully completed surveys amounted to 51%.

The demographic information examined in this study included: gender, job title, age group, and race. Survey respondents were predominantly administrators, (65.2%). In

addition, respondents were primarily Caucasian, (87.6%), females (64.0%) and between the ages of 46-55 (35.1%). See Table 1 for detailed results for respondent profile.

Table 1

Respondent Profile

	N	%
Gender (*n* = 339)		
Female	217	64.0%
Male	122	36.0%
Job Title (*n* = 342)		
Administrator	223	65.2%
Other	36	10.5%
Director of Rehab Services	32	9.4%
CEO/President	29	8.5%
Program Director	18	5.3%
Vice President	4	1.2%
Age group (*n* = 339)		
18-25	1	0.3%
26-35	40	11.8%
36- 45	87	25.7%
46- 55	119	35.1%
56- 60	55	16.2%
61+	37	10.9%
Race (*n*= 340)		
Caucasian	298	87.6%
Black/African American	24	7.1%
Don’t know or prefer not to answer	9	2.6%
Other	4	1.2%
Asian	3	0.9%
Native-American or Alaska Native	1	0.3%
Native-Hawaiian or other Pacific Islander	1	0.3%
Hispanic or Latino	0	0.0%

Respondents were also asked various demographic questions pertaining solely to the facility they represented. Survey respondents worked primarily for skilled nursing facilities (44.7%) followed by hospitals (18.3%). Approximately half of the respondents identified long term care as the primary level of care and largely serving older adults (88.5%). Most respondents reported the facilities they worked at were regulated by the Center for Medicaid and Medicare Services, (81.8%). Approximately half of the respondents represented 100+ bed facilities and indicated their primary source of funding as "for profit," (57.2%). Lastly, the majority of respondents were billed by Medicaid (87.2%) and Medicare (72.6%). See Table 2 for detailed descriptions for facility demographics.

Table 2

Facility Demographics

	N	%
Primary Facility Type (*n* = 416)		
Skilled Nursing Facility	186	44.7%
Hospital	76	18.3%
Assisted Living	57	13.7%
Residential/Transitional	45	10.8%
Other	29	7.0%
CCRC	23	5.5%
Primary Level of Care (*n* = 415)		
Long term care	219	52.8%
Acute	64	15.4%
Rehabilitation	58	14.0%
Other	29	7.0%
Assisted Living	22	5.3%

Age Group Served (*n* = 409)		
Older Adults	349	88.5%
Adults	182	44.6%
Adolescents	98	24.0%
Pediatrics	65	15.9%
Number of Beds (*n* = 373)		
1-100	162	44.3%
101+	204	55.7%
Primary Source(s) of Funding (*n* = 415)		
For profit	237	57.2%
Non-profit	138	33.3%
State/local government	114	27.5%
Federal Government	102	24.6%
Other	33	8.0%
Private Pay	20	4.8%
Facility Bill (*n* = 413)		
Medicaid	360	87.2%
Private Insurance	327	79.2%
Medicare	300	72.6%
Private Pay	120	29.1%
Other	55	28.3%
Hospice	24	5.8%
Regulated by CMS (*n* = 412)		
Yes	336	81.8%
No	52	12.2%
I don’t know	23	5.6%

Results will be detailed within subsequent sections in relationship to the five research questions posed in this study.

Research Question 1

What are the determinants of hiring recreational therapy professionals within health care facilities in North Carolina?

Familiarity with RT services was the primary variable examined as a determinant of respondents having or not having a LRT on staff. Descriptive results revealed the majority (68.5%) of survey respondents indicated that they were "extremely" or "very" familiar with recreational therapy (RT) services. In fact, the following paragraphs reveal that familiarity with RT services was identified as a determinant of having a LRT on staff. See Table 3 for detailed description of familiarity with RT versus other treatment services.

Table 3

Respondents' Familiarity of Treatment Services

	N	Extremely Familiar n (%)	Very Familiar n (%)	Somewhat Familiar n (%)	Slightly Familiar n (%)	Not at all Familiar n (%)
Activity Services	404	226 (55.9%)	102 (25.2%)	39 (9.7%)	16 (4.0%)	21 (5.2%)
Occupational Therapy	407	219 (53.8%)	137 (33.7%)	34 (8.4%)	12 (2.9%)	5 (.2%)
Physical Therapy	409	225 (55.0%)	134 (32.8%)	33 (8.1%)	11 (2.7%)	6 (1.5%)
Recreational Therapy	397	151 (38.0%)	121 (30.5%)	84 (21.2%)	27 (6.8%)	14 (3.5%)
Speech Pathology	408	207 (50.7%)	126 (30.9%)	48 (11.8%)	16 (3.9%)	11 (2.7%)

To determine the relationship between having a LRT on staff and familiarity with RT, an independent samples *t*-test was calculated comparing the mean scores of the responses to the statement, "How familiar are you with RT," across two groups: those facilities that do have a LRT on staff and those facilities that do not have a LRT on staff. Familiarity with RT was measured on a 5-point Likert scale ranging from (1) "*extremely familiar*" to (5) "*not at all familiar*." Note that lower mean scores represent more positive responses. Having a LRT on staff was indicated by "*yes*" (LRT on staff) or "*no*" (LRT not on staff). The *t*-test was statistically significant (t (342) = 4.967, p = .000) showing that those respondents who did not have a LRT at their facility professed lower familiarity (M = 2.13) then those who did have a LRT (M = 1.45). Statistical evidence confirms hypothesis one.

To examine differences between familiarity with RT among respondent groups representing different facility types, a one-way analysis of variance (ANOVA) was completed to compare the means between six facility types: hospital, skilled nursing facility, residential/ transitional, assisted living, continued care retirement community, and other. The model was statistically significant (F(5,390) = 4.22, p = .001). Post hoc analysis using the Tukey's HSD was completed to determine where significant differences were found between facility types. This test indicated that administrators in hospitals had a significantly lower familiarity with RT (M = 2.29, SD = 1.080) than those in skilled nursing facilities (M = 1.86, SD = .966), p = .021. Likewise, Tukey's HSD showed "other," primarily mental health settings, having a significantly lower familiarity

with RT (M = 2.52, SD = .986) than respondents in skilled nursing facilities (M = 1.86, SD = .966), p =.012.

In consideration of hypothesis two, additional statistics were performed to investigate more deeply into respondents' true familiarity with RT. The researcher selected cases from the database to create a subgroup including only those respondents who indicated being "extremely" and "very" familiar with RT (N = 272). Several variables served to determine actual familiarity with RT: medically prescribed, alternative medicine, interdisciplinary team, education, cost of service, licensure recognition, fun activities for clients in their downtime, recreation-based interventions, and RT the same term as Therapeutic Recreation (TR). Results showed the following for this subgroup: 57.1% agreed RT was medically prescribed, 59.6% agreed RT was an alternative medicine, 80.6% agreed RT was a usual part of the interdisciplinary team, 46.6% agreed the training and education involved with RT is either "extremely" or "very" rigorous, 30.7% agreed RT was an "extremely" or "very" expensive service, 77.3% agreed RT requires licensure in North Carolina, 61.8% strongly agreed or agreed RT provides clients with fun activities to do in their down time, 96.5% agreed RT provides recreation based interventions, and 64.6% agreed RT was the same term as therapeutic recreation, Statistical evidence supports hypothesis two, in which respondents who indicated being "extremely" and "very" familiar with RT services were not representative of their true familiarity. Following this analysis, a Pearson's correlation was completed between respondents' familiarity with RT and the same RT identifier

variables described above. A statistically significant relationship between RT familiarity and RT being a usual part of the interdisciplinary team was found with a moderate positive correlation ($r(358) = .307$, $p = .000$). Also, a weak positive correlation was found with a statistical significant relationship between familiarity with RT and recreation-based interventions ($r(367) = .189$, $p = .000$).

Overall, descriptive results indicated that RT is the least familiar service of the five treatment services. In fact, even those respondents who perceived being "extremely" and "very" familiar with RT was not reflective of actual familiarity with RT. Finally, those respondents who identified having a LRT at their facilities were more familiar with RT than those who did not have a LRT on staff. The remaining research questions also identify other determinants of having a LRT on staff and are discussed within their respective sections.

Research Question 2

What types of facilities hire or do not hire recreational therapists?

Each respondent had the opportunity to identify which treatment services are provided in the various units that comprise their facility. Results include skilled nursing units (17.5%), rehabilitation units (16.9%), and behavioral/ mental health units (9.6%) are the top three units in which RT services were found. See Table 4 for detailed description of unit types where all treatment services practice.

Table 4

Units in Facility where Treatment Services are Provided

Treatment Service	N	%
Activity Services		
Skilled Nursing	209	64.3%
Rehabilitation	153	48.9%
Assisted Living	160	47.8%
Memory Care	111	34.8%
Behavioral/Mental Health	50	16.6%
Oncology	8	2.8%
Occupational Therapy		
Skilled Nursing	223	68.6%
Rehabilitation	213	68.1%
Assisted Living	123	36.7%
Memory Care	82	25.7%
Behavioral/Mental Health	37	12.3%
Oncology	25	8.7%
Physical Therapy		
Skilled Nursing	223	68.6%
Rehabilitation	213	68.1%
Assisted Living	129	38.5%
Memory Care	85	26.6%
Behavioral/Mental Health	34	11.3%
Oncology	29	10.0%
Recreational Therapy		
Skilled Nursing	57	17.5%
Rehabilitation	53	16.9%
Behavioral/Mental Health	29	9.6%
Memory Care	26	8.2%
Assisted Living	24	7.2%
Oncology	7	2.4%

Speech Pathology		
Rehabilitation	206	65.8%
Skilled Nursing	213	65.5%
Assisted Living	118	35.2%
Memory Care	81	25.4%
Behavioral/Mental Health	29	9.6%
Oncology	23	8.0%
"We don't have this unit"		
Oncology	259	89.6%
Behavioral/Mental Health	235	77.8%
Memory Care	201	63.0%
Assisted Living	171	51.0%
Skilled Nursing	102	31.4
Rehabilitation	89	28.4%

A big indicator of what treatment services were offered at facilities can be how the clients are matched to the service (e.g., physician order, patient request, etc.). Respondents identified how their facility recommended clients to treatment services. Approximately 60% of respondents did not offer RT services. The top recommendation categories for RT included "physician referrals" (19.5%) and "routinely offered to clients" (19.2%). The remaining responses received less than 10% for each item. See Table 5 for detailed results of how clients access the various treatment services.

Table 5

Matching and Recommending Clients to Treatment Services

	N	%
Matching/Recommending clients to *Activity Services* (*n* = 356)		
Routinely offered to all clients	275	77.2%
Patient request	68	19.1%
Caregiver request	59	16.6%
Service not offered	55	15.4%
Nursing referral	55	15.4%
Physician referral	33	9.3%
Case manager referral	32	9.0%
Matching/Recommending clients to *Occupational Therapy* (*n* = 363)		
Physician referral	313	86.2%
Nursing referral	176	48.5%
Patient request	142	39.1%
Caregiver request	132	36.4%
Case manager referral	93	25.6%
Routinely offered to all clients	45	12.4%
Service not offered	22	6.1%
Matching/Recommending clients to *Physical Therapy* (*n* = 362)		
Physician referral	318	87.8%
Nursing referral	177	48.9%
Patient request	141	39.0%
Caregiver request	131	36.2%
Case manager referral	90	24.9%
Routinely offered to all clients	43	11.9%
Service not offered	21	5.8%
Matching/Recommending clients to *Recreational Therapy* (*n* = 323)		
Service not offered	192	59.4%
Physician referral	63	19.5%
Routinely offered to all clients	62	19.2%
Patient request	31	9.6%
Nursing referral	26	8.0%
Caregiver request	25	7.7%
Case manager referral	19	5.9%

Matching/Recommending clients to *Speech Pathology* (*n* = 363)		
Physician referral	315	86.8%
Nursing referral	174	47.9%
Patient request	131	36.1%
Caregiver request	122	33.6%
Case manager referral	90	24.8%
Routinely offered to all clients	39	10.7%
Service not offered	25	6.9%

Those respondents who did have a LRT (*n* = 58) on staff also identified the salary, the number of LRTs at the facility, the role of the LRT, and who, if anyone, the LRT supervised. The majority of respondents revealed the following information: the starting salary of a LRT is $26- 30, 999 (34.0%), LRTs supervise activity professionals and volunteers (51.0%), and both LRTs (67.0%) and LRTAs (83.3%) main roles are direct treatment. See Table 6 for detailed results of all the LRT categories.

Table 6

LRT Information at those Facilities that do have a LRT on Staff

	N	%
# of LRTs at facility with specified roles		
# LRT administrators	5	4.7%
# LRT direct treatment only	71	67.0%
# LRT blended role	30	28.3%
# of LRTAs at facility with specified roles		
# LRTA administrators	0	0.0%
# LRTA direct treatment	10	83.3%
# LRTA blended role	2	16.7%

Who does the LRT at your facility supervise? (*n* = 51)		
Activity Professionals	26	51.0%
Volunteers	26	51.0%
Other LRT's	10	19.6%
Recreation Workers	10	19.6%
N/A (LRT is not supervisor)	12	23.5%
Other	6	11.8%
What is starting salary for a LRT at your facility? (*n* = 47)		
$20-25,999	8	17.0%
$26-30,999	16	34.0%
$31-35,999	15	31.9%
$36-40,999	2	4.3%
$41-45,999	3	6.4%
$46-50,999	2	4.3%
$51,000+	1	2.1%

All demographic information pertaining to describing the facility was analyzed to determine if any variables affected having a LRT on staff. Cross tab chi-squares analyses were completed for the following facility related items: primary facility type, primary level of care, age group served, primary source(s) of funding, facility billing, and being CMS regulated. The following were not statistically significant: adults x^2 (1, N= 350) = 2.506, p = .113, older adults x^2 (1, N= 350) = .998, p = .318, number of beds x^2 (1, N= 313) = 1.961, p = .161, state/local government x^2 (1, N= 356) = 1.005, p = .316 , federal government x^2 (1, N= 356) =.027, p = .868 , private pay (funding) x^2 (1, N= 356) = .002, p = .965, other (funding) x^2 (1, N= 356) = .951, p = .329, Medicaid x^2 (1, N= 354) = .621, p = .431 , hospice x^2 (1, N= 354) = .106, p = .745, private pay (billing) x^2 (1, N= 354)= 1.083, p = .298, other (billing) x^2 (1, N= 354)= .771, p= .380, and CMS regulated x^2 (2, N= 353)= 2.327, p = .312.

A cross tab Chi-square analysis indicated the following eight demographic variables were statistically associated with having a LRT on staff: primary facility type x^2 (5, N= 355) = 27.453, p = .000, primary level of care x^2 (5, N= 356) = 16.493, p = .006, pediatrics x^2 (1, N = 350) = 11.692, p = .001, adolescents x^2 (1, N = 316) = 5.675, p = .017, for profit x^2 (1, N = 356) = 11.228, p = .001, non-profit x^2 (1, N = 356) = 21.452, p = .000, Medicare x^2 (1, N = 354) = 8.949, p = .003, and private insurance x^2 (1, N = 354) = 7.441, p = .006. Specifically, hospitals were the most likely facility type to hire a LRT followed by "other", continuing care retirement communities (CCRCs), residential facilities, assisted livings (ALs), and skilled nursing facilities (SNFs). Similar to SNFs being the least likely to have LRTs on staff, facilities that were primarily long term care and serving older adults were also the least likely to have LRTs on staff in their respective categories. Rehabilitation and acute were the most likely level of care types to have LRTs, while facilities treating pediatrics and adolescents were more likely to hire a LRT than those facilities with adults and older adults. Non-profit agencies are more likely to hire LRTs than for-profit facilities. Finally, a higher percentage of respondents indicated having a LRT on staff with their facility billing private insurance than those that did not have a LRT on staff.

Facility demographics across treatment services with the most preferred next hire item were also examined by conducting crosstab chi-squares. The researcher created a subgroup by selecting only cases of treatment services identified as the most preferred next hire. Four of the five treatment services were included in analysis due to inadequate

cell size for speech language pathology. In addition, some of the facility demographic items had to be collapsed for the same reason. The following items were not statistically different within the most preferred discipline variable: old adults x^2 (3, N = 363) = 6.53, p = .088; number of beds x^2 (3, N= 325) = 3.73, p = .293; federal government x^2 (3, N = 369) = .96, p = .812; state/local government x^2 (3, N = 369) = 2.41, p = .490; hospice x^2 (3, N = 367) = 2.00, p = .572; other (funding) x^2 (3, N = 369) = 3.03, p = .387; private pay (billing) x^2 (3, N = 367) = 4.43, p = .219; other (billing) x^2 (3, N = 367) = 2.63, p = .452.

The most preferred next hire item statistically differed among the following remaining facility demographics. First, the percentage of participants that answered most preferred next hire differed by primary facility type x^2 (12, N = 368) = 1.03, p = .000. It is important to note that due to inadequate n cell size, "other," or primarily mental health settings, was integrated with CCRCs in data analysis; therefore, CCRCs in this analysis also represent "other." Results showed activity professionals (APs) were the most preferred next hire for skilled nursing facilities (SNFs) followed by assisted living communities (ALs), continuing care retirement communities (CCRCs), residential facilities, and hospitals. Occupational therapists (OTs) were the most preferred next hire for SNFs followed by hospitals, residential facilities, CCRCs, and ALs. Physical therapists (PTs) were the most preferred next hire for SNFs followed by hospital, ALs, while CCRCs and residential facilities were equally last. Finally, recreational therapists (RTs) were the most preferred next hire for SNFs followed by CCRCs, ALs, hospitals, and residential facilities. Primary level of care, x^2 (9, N = 368) = 45.28, p = .000 also

provided a statistical difference with the most preferred next hire item. Specifically, AP's most preferred next hire was indicated by long term care (LTC), ALs, rehab and acute. OTs' most preferred next hire was LTC, rehab, acute, and ALs. PT's most preferred next hire was LTC, acute, rehab and ALs. Finally, RT's' most preferred next hire was identified within LTC, ALs, acute, and rehab.

Three of the four client age groups produced statistically significant differences. There was a statistical difference among most preferred next hire and those respondents who worked in facilities that serve and do not serve pediatrics, x^2 (3, N = 363) = 35.64, p = .000. Higher percentages were found within the four most preferred treatment services with not treating pediatrics. In addition, PTs were identified as the most preferred for those facilities that treated pediatrics followed by OTs, RTs, and APs. There was also a statistical difference among most preferred next hire and those respondents who worked in facilities that serve and do not serve adolescents, x^2 (3, N = 324) = 28.20, p = .000. Higher percentages were found within the four most preferred treatment services with not treating adolescents. Also, PTs were identifies as the most preferred next hire followed by OTs, APs, RTs. In addition, a statistical difference was found among most preferred next hire and those respondents who worked in facilities that serve and do not serve adults x^2 (3, N = 363) = 19.53, p = .000. Higher percentages were found within OT and PT most preferred items with treating adults at their corresponding facilities. RTs and APs had higher most preferred next hire percentages within those facilities that did not treat pediatrics.

A statistical difference was found among most preferred next hire and those respondents who worked at facilities that were for profit, x^2 (3, N = 369) = 9.84, p = .020. Specifically, higher percentages were found within OTs, PTs and APs most preferred items with facilities being for profit. Thus, RTs were the only most preferred next hire treatment service to have a higher proportion identifying not being for profit. For profit facilities identified APs as the most preferred next hire followed by OTs, PTs and RTs. A statistical difference was also found among most preferred next hire and those respondents who worked at facilities that were non-profit, x^2 (3, N = 369) = 14.11, p = .003. Specifically, higher percentages were found for all four treatment services as most preferred next hire with not being a non-profit facility. Non-profit facilities identified PTs as the most preferred next hire followed by RTs, APs, and OTs.

Statistical differences were found among most preferred next hire and those respondents that worked at facilities that bill both Medicaid, x^2 (3, N = 367) = 10.08, p = .018 and Medicare, x^2 (3, N = 367) = 52.52, p = .000. Specifically, higher percentages were predominantly found with most preferred next hire and the facility billing Medicaid and Medicare. This was true for all treatment services excluding APs as the most preferred next hire, who were the only group to have a larger percentage within not billed by Medicare. A statistical difference was found among most preferred next hire and those respondents who worked at facilities that were CMS regulated, x^2 (6, N = 366) = 23.24, p = .001. Specifically, all treatment services had higher percentages within being CMS regulated; however, PTs were the most preferred by facilities that were CMS regulated

followed by APs, RTs, and OTs. Finally, there were statistical difference found among most preferred next hire and those respondents who worked at facilities that bill private insurance, x^2 (3, N= 367) = 31.41, p = .000. All treatment services that were most preferred next hires showed a higher proportion of respondents within those facilities that do bill private insurance. Such facilities identified PTs as the most preferred next hire followed by APs, RTs, and OTs.

As the findings from this study revealed, facility are statistically associated with the inclusion or exclusion of RT services. Having a LRT on staff could also relate to administrative demographics. As a tangential result, the researcher computed crossed tabulations using the respondents' demographics (i.e., job title, age, gender, and race) against whether or not there is a LRT on staff. Most variables were not statistically significant: gender x^2 (1, N = 339) = 1.67, p = .197; age x^2 (5, N = 338) = 5.02, p = .413; race x^2 (6, N = 332) = 10.22, p = .116. The respondents' job title was statistically significant with having a LRT on staff x^2 (4, N = 341) = 11.97, p = .018. Interestingly, data showed that although respondents with administrators as job titles represented almost half of agencies that had LRTs on staff in this sample, they were the least likely group to have LRTs at their facilities. Moreover, Directors of Rehabilitation Services was most likely to have LRTs on staff followed by CEOs, "other," and program directors. It is inconclusive whether persons in certain title positions have better recognition of whether or not they actually have LRTs on staff. Since no underlying theoretical proposition

associating administrator demographics with LRT hiring decisions is being assessed in this study, these results are for informational value only.

Research Question 3

How does perceived occupational prestige of recreational therapy impact the hiring decision?

As mentioned in chapter three, the researcher constructed eight items to function as a scale to measure occupational prestige: medically prescribed, alternative medicine, usual part of the interdisciplinary team, recreation-based interventions, cost of service professional, rigor of education/training, licensure recognition, and provide fun activities for clients to do in their down time. Due to low reliability scores, these items are treated in this chapter as individual variables rather than as a scalar measure of prestige of each of the five treatment services. Therefore, this research question is better phrased as "How do perceptions of occupational characteristics impact the hiring decision"?

An independent samples *t*-test was calculated comparing mean scores on each of the eight perception variables between those facilities who *did* and *did not* have LRT's on staff. The following t-tests were not statistically associated with: medically prescribed (t (339) = .544, p = .587); alternative medicine (t (339) = - .093, p = .926); downtime (t (339) = -.901, p = .368); rigorous (t (343) = .388, p = .699); recognition of licensure (t (344) = .804, p = .422).

There were statistically significant differences in means for variables of: interdisciplinary team (t (332) = 4.769, p = .000); recreation based interventions (t (346)

= 3.388, p = .001); and expensive (t (339) = -4.138, p = .000). Specifically, those respondents who had LRT's on staff indicated lower mean scores for RT as a usual part of the interdisciplinary team (M = 1.38, SD = .644), providing recreation based interventions (M = 1.14, SD = .348) and being less expensive (M = 3.39, SD = .818) than those respondents who did not have a LRT. In addition, although not statistically significant, the mean scores revealed those who have LRT's agree more that RT is medically prescribed, requires more rigorous training/education and disagree about mainly providing clients with things to do in their down time than those who did not have a LRT on staff.

The researcher was interested to obtain the perceptions specifically of those respondents who indicated recreation therapy as the number one or most preferred hire for expanded services. Therefore, the researcher selected only those respondents who identified RT as their most preferred hire (n= 75). Using only these select cases, results showed the following demographics: working in skilled nursing facilities (50%), long term care (41%), serving older adults (86.7%), 100+ beds (57.1%), Medicaid (82.7%)/Medicare (77.3%) services, private insurance (80%), CMS regulated (82.4%), and administrators (75.0%). In addition, the following characteristics pertaining to RT were found: not having a LRT on staff (83.1%), never had a LRT on staff before (86%), extremely/very familiar (86.5%), medically prescribed (56.9%), alternative medicine (53.6%), interdisciplinary team (70.4%), recreation-based interventions (94.4%),

downtime (58.6%), extremely/very rigorous education (44.4%), extremely/very expensive (37.1%), extremely/very beneficial (85.5%).

Research Question 4

What is the perceived prestige of the recreational therapy occupation compared to the perceived prestige levels of competitor professions?

The researcher was interested in developing a hierarchy of occupational prestige based on the five treatment services; however, this was not plausible due to low internal consistencies between items as mentioned in research question three. Subsequently, research question four and hypothesis four were inconclusive. Again, the perception variables include the following survey items: medically prescribed, alternative medicine/therapy, interdisciplinary team, recreation-based interventions, rigorous training/education, service cost, licensure recognition and fun activities for clients to do in their downtime. With the exception of licensure recognition, which was RT-specific, the researcher was able to gain perceptions of all treatment services by comparing each profession's individual score among the perception variables listed above. This research question is better phrased as "what are administrator perceptions of the RT occupation compared to competitor professions"?

Respondents largely agreed that physical therapy (98.2%), speech therapy (97.4%), and occupational therapy (96.1%) were medically prescribed therapies and then there was a significant drop-off followed by RT (54.9%) and activity services (31%). See

Table 7 for detailed results of respondents' perceptions of the five treatment services as medically prescribed therapies.

Table 7

Respondents' Perceptions of Medically Prescribed Treatment Services

	N	Strongly Agree n (%)	Agree n (%)	Disagree n (%)	Strongly Disagree n (%)
Activity Services	375	25 (6.7%)	91 (24.3%)	191 (50.9%)	68 (18.1%)
Occupational Therapy	390	316 (81.0%)	59 (15.1%)	12 (3.1%)	3 (0.8%)
Physical Therapy	390	331 (84.9%)	52 (13.3%)	5 (1.3%)	2 (0.5%)
Recreational Therapy	377	77 (20.4%)	130 (34.5%)	141 (37.4%)	29 (7.7%)
Speech Pathology	387	317 (81.9%)	60 (15.5%)	6 (1.6%)	4 (1.0%)

The National Center for Complementary and Alternative Medicine (NCCAM) (2010) defines alternative medicine as "a group of diverse medical and health care systems, practices, and products that are not generally considered to be part of conventional medicine" (http://nccam.nih.gov/health/whatiscam). Respondent's viewed activity services (61.4%) and RT (58.6%) as alternative medicine/therapies followed by a drastic drop-off which occupational therapy (29.1%), physical therapy (28.3%), and speech language pathology (26.7%) followed. See Table 8 for detailed results of respondent's perceptions of the five treatment services as alternative medicines.

Table 8

Respondents' Perceptions of Alternative Medicine Treatment Services

	N	Strongly Agree n (%)	Agree n (%)	Disagree n (%)	Strongly Disagree n (%)
Activity Services	376	103 (27.4%)	128* (34.0%)	101 (26.9%)	44 (11.7%)
Occupational Therapy	364	34 (9.3%)	72 (19.8%)	146* (40.1%)	112 (30.8%)
Physical Therapy	360	35 (9.7%)	67 (18.6%)	148* (41.1%)	110 (30.6%)
Recreational Therapy	375	83 (22.1%)	137* (36.5%)	100 (26.7%)	55 (14.7%)
Speech Pathology	360	31 (8.6%)	65 (18.1%)	152* (42.2%)	112 (31.1%)

Respondents had to identify which treatment services they viewed as being a usual part of the interdisciplinary or treatment team. Occupational, physical and speech therapies had the highest ratings of being considered interdisciplinary members ranging from 91.9% - 94.5% followed by activity services (81.7%) and RT (74.2%). See Table 9 for detailed results of respondent's perceptions of the five treatment services as an interdisciplinary team member.

Table 9

Respondents' Perceptions of Interdisciplinary Team Members

	N	Strongly Agree n (%)	Agree n (%)	Disagree n (%)	Strongly Disagree n (%)
Activity Services	383	219 (57.2%)	94 (24.5%)	52 (13.6%)	18 (4.7%)
Occupational Therapy	383	260 (67.9%)	102 (26.6%)	17 (4.4%)	4 (1.0%)
Physical Therapy	382	266 (69.6%)	94 (24.6%)	16 (4.2%)	6 (1.6%)
Recreational Therapy	369	155 (42.0%)	119 (32.2%)	84 (22.8%)	11 (3.0%)
Speech Pathology	382	246 (64.4%)	105 (27.5%)	24 (6.3%)	7 (1.8%)

Another perception obtained from the respondent included the item concerning RT requiring licensure to practice in the state of North Carolina. Over two-thirds of the sample agreed RT required licensure in North Carolina (78.5%). See Table 10 for details.

Table 10

Respondents' Perceptions of RT Requiring Licensure in North Carolina

	N	Strongly Disagree n (%)	Disagree n (%)	Agree n (%)	Strongly Agree n (%)
RT are required to have licensure in NC	368	43 (11.7%)	36 (9.8%)	197 (53.5%)	92 (25.0%)

Recreational therapy was identified as the highest provider of recreation-based interventions (96.1%) followed by activity services (81.7%), occupational therapy (68.4%), physical therapy (60.1%), and speech therapy (41.4%). See Table 11 for more details of respondent's perceptions of services providing recreation-based interventions

Table 11

Respondents' Perceptions of Recreation-based Interventions

	N	Strongly Agree n (%)	Agree n (%)	Disagree n (%)	Strongly Disagree n (%)
Activity Services	382	256 (67.0%)	110 (28.8%)	11 (2.9%)	5 (1.3%)
Occupational Therapy	370	85 (23.0%)	168 (45.4%)	100 (27.0%)	17 (4.6%)
Physical Therapy	366	61 (16.7%)	159 (43.4%)	124 (33.9%)	22 (6.0%)
Recreational Therapy	381	254 (66.7%)	112 (29.4%)	10 (2.6%)	5 (1.3%)
Speech Pathology	365	35 (9.6%)	116 (31.8%)	177 (48.5%)	37 (10.1%)

The majority of respondents identified activity services with providing clients fun activities to do in their downtime (79.2%) followed by RT (60.2%). The remaining therapies received low percentages ranging from 9.6% to 18.2%. See Table 12 for more details of respondent's perceptions toward the five treatment services providing fun activities for clients to do in their downtime.

Table 12

Respondents' Perceptions of Fun Activities for Client Downtime

	N	Strongly Agree n (%)	Agree n (%)	Disagree n (%)	Strongly Disagree n (%)
Activity Services	380	185 (48.7%)	116 (30.5%)	58 (15.3%)	21 (5.5%)
Occupational Therapy	363	10 (2.8%)	56 (15.4%)	212 (58.4%)	85 (23.4%)
Physical Therapy	359	8 (2.2%)	51 (14.2%)	209 (58.2%)	91 (25.3%)
Recreational Therapy	377	107 (28.4%)	120 (31.8%)	111 (29.4%)	39 (0.3%)
Speech Pathology	356	7 (2.0%)	27 (7.6%)	222 (62.4%)	100 (28.1%)

Survey respondents had to indicate how rigorous they perceived the training and education for each treatment service. Most respondents indicated the training/education for physical therapy being "extremely" or "very" rigorous (92.9%) and similarly for speech therapy (92.1%) and occupational therapy (86.3%). However, RT received around half the scores of physical, speech, and occupational therapies (45.1%). Finally, rigor scores for activity services were substantially lower than all five treatment services (9.5%). See Table 13 for more details of respondent's perspectives of the rigor of education and training associated with five treatment services.

Table 13

Respondents' Perceptions of Rigor of Service Professionals' Education

	N	Extremely Rigorous n (%)	Very Rigorous n (%)	Somewhat Rigorous n (%)	Slightly Rigorous n (%)	Not at all Rigorous n (%)
Activity Professional	378	5 (1.3%)	31 (8.2%)	108 (28.6%)	140 (37.0%)	94 (24.9%)
Occupational Therapist	380	138 (36.3%)	190 (50.0%)	41 (10.8%)	9 (2.4%)	2 (0.5%)
Physical Therapist	381	172 (45.1%)	182 (47.8%)	21 (5.5%)	4 (1.0%)	2 (0.5%)
Recreational Therapist	373	48 (12.9%)	120 (32.2%)	135 (36.2%)	63 (16.9%)	7 (1.9%)
Speech Pathologist	380	162 (42.6%)	188 (49.5%)	21 (5.5%)	5 (1.3%)	4 (1.1%)

Respondent's identified physical (84.9%), speech (83.1%), and occupational (80.8%) therapists as being "extremely" and "very expensive" services. Conversely, less than half of the respondents perceived RT in the same cost range (45.1%) and even fewer for activity professionals (10.1%). See Table 14 for more details.

Table 14

Respondents' Perceptions of Cost for Service Professionals

	N	Extremely Expensive n (%)	Very Expensive n (%)	Somewhat Expensive n (%)	Slightly Expensive n (%)	Not at all Expensive n (%)
Activity Professional	369	15 (4.1%)	22 (6.0%)	101 (27.4%)	133 (36.0%)	98 (26.6%)
Occupational Therapist	375	135 (36.0%)	168 (44.8%)	51 (13.6%)	9 (2.4%)	12 (3.2%)
Physical Therapist	376	156 (41.5%)	163 (43.4%)	40 (10.6%)	6 (1.6%)	11 (2.9%)
Recreational Therapist	371	55 (14.8%)	72 (19.4%)	139 (37.5%)	83 (22.4%)	22 (5.9%)
Speech Pathologist	373	160 (42.9%)	150 (40.2%)	46 (12.3%)	5 (1.3%)	12 (3.2%)

Pearson's product-moment correlations were calculated for the relationship between the five treatment services in all RT perspective variables. The first variable tested was medically prescribed scores. A moderate positive correlation was found ($r(369) = .513$, $p = .000$), indicating a statistically significant relationship between activity services and RT medically prescribed scores. A strong positive correlation was also found ($r(390)= .747$, $p = .000$) between physical and occupational therapy medically prescribed scores, also indicating a statistically significant relationship between the variables. Speech and occupational therapies medically prescribed scores produced a strong positive correlation and statistically significant relationship ($r(387)=.787$, $p = .000$). The final strong positive correlation was found, ($r(387)= .811$, $p = .000$) between

speech and physical therapy medically prescribed scores. See Appendix A, Table 5 for all correlations associated with medically prescribed.

Pearson's product-moment correlations were calculated for the relationship between the five treatment services and alternative medicine scores. Every relationship was significantly correlated. The main findings include a negative, correlation was found ($r(363)=-.125$, $p = .017$) with a statistically significant relationship between RT and activity services alternative medicine scores. Conversely, similar high positive correlations were found with RT and OT alternative medicine scores, ($r(361)=.539$, $p = .000$); RT and PT alternative medicine scores ($r(357)= .532$, $p = .000$); and RT and ST alternative medicine scores ($r(357)= .516$, $p =.000$). In addition, high positive correlations and statistically significant relationships were found between ST and PT alternative medicine scores ($r(356)= .963$, $p = .000$); ST and OT alternative medicine scores ($r(360)= .949$, $p = .000$); and PT and OT alternative medicine scores ($r(360)= .967$, $p = .000$). See Appendix A, Table A6 to view all correlations associated with alternative medicine.

Pearson's product-moment correlations were calculated for the relationship between the five treatment services and being a usual part of the interdisciplinary team. Again, all relationships were significantly correlated. The main results include a moderate positive correlation and statistically significant relationship was found ($r(364)= .358$, $p = .000$) between RT and Activity Services interdisciplinary scores. Similar moderate positive correlation and statistically significant relationships were found

between RT and OT interdisciplinary scores ($r(367) = .488$, $p = .000$); RT and PT interdisciplinary scores ($r(365) = .424$, $p = .000$); and RT and ST interdisciplinary scores ($r(366) = .426$, $p = .000$). In addition, similar high positive correlations and statistically significant relationships were found between PT and ST interdisciplinary scores ($r(380) = .895$, $p = .000$; ST and OT interdisciplinary scores ($r(382) = .860$, $p = .000$); PT and OT interdisciplinary scores ($r(381) = .912$, $p = .000$). See Appendix A, Table A7 to view all correlations associated with interdisciplinary team.

Pearson's product-moment correlations were calculated for the relationship between the five treatment services and providing recreation-based interventions. Again, all relationships were significantly correlated. The main results include a moderate positive correlation and statistically significant relationship was found ($r(376) = .424$, $p = .000$) between RT and Activity Services recreation based scores. Similar weak positive correlations and statistically significant relationships were found between RT and OT rigor scores ($r(367) = .240$, $p = .000$); RT and PT rigor scores ($r(364) = .178$, $p = .000$); and RT and ST rigor scores ($r(363) = .153$, $p = .000$). In addition, similar high positive correlations and statistically significant relationships were found between PT and ST rigor scores ($r(363) = .707$, $p = .000$); ST and OT rigor scores ($r(364) = .629$, $p = .000$); PT and OT rigor scores ($r(365) = .704$, $p = .000$). See Appendix A, Table A8 to view all correlations associated with recreation-based interventions.

Pearson's product-moment correlations were calculated for the relationship between the five treatment services and providing fun activities for clients to do in their

downtime. Again, all relationships were significantly correlated. The main results include a high positive correlation and statistically significant relationship was found ($r(370)= .585$, $p = .000$) between RT and Activity Services downtime scores. Moderate positive correlations and statistically significant relationships were found between RT and OT downtime scores ($r(361)= .440$, $p = .000$); RT and PT downtime scores ($r(357)= .410$, $p = .000$); and RT and ST downtime scores ($r(354)= .390$, $p = .000$). In addition, similar high positive correlations and statistically significant relationships were found between PT and ST downtime scores ($r(353)= .873$, $p = .000$); ST and OT downtime scores ($r(356)= .841$, $p = .000$); PT and OT downtime scores ($r(358)= .879$, $p = .000$). See Appendix A, Table A9 to view all correlations associated with downtime.

Pearson's product-moment correlations were calculated for the relationship between the five treatment services and rigor of education/training. All but one relationship was significantly correlated. The main results include a moderate positive correlation and statistically significant relationship was found ($r(368)= .496$, $p = .000$) between RT and Activity Services rigor scores. Similar moderate/weak positive correlations and statistically significant relationships were found between RT and OT rigor scores ($r(372)= .425$, $p = .000$); RT and PT rigor scores ($r(373)= .345$, $p = .000$); and RT and ST rigor scores ($r(373)= .333$, $p = .000$). In addition, similar high positive correlations and statistically significant relationships were found between PT and ST rigor scores ($r(380)= .798$, $p = .000$); ST and OT rigor scores ($r(379)= .775$, $p = .000$);

PT and OT rigor scores ($r(380) = .818$, $p = .000$). See Appendix A, Table A10 to view all correlations associated with rigor.

The final Pearson's product-moment correlations were calculated for the relationship between the five treatment services and professional service cost scores. Again, all relationships were significantly correlated. The main results include a moderate positive correlation and statistically significant relationship was found ($r(361) = .521$, $p = .000$) between RT and Activity Services service cost scores. Similar moderate positive correlations and statistically significant relationships were found between RT and OT service cost scores ($r(369) = .468$, $p = .000$); RT and PT service cost scores ($r(369) = .404$, $p = .000$); and RT and ST service cost scores ($r(367) = .409$, $p = .000$). In addition, similar high positive correlations and statistically significant relationships were found between PT and ST service cost scores ($r(372) = .865$, $p = .000$); ST and OT service cost scores ($r(372) = .874$, $p = .000$); PT and OT service cost scores ($r(374) = .911$, $p = .000$). See Appendix A, Table A11 to view all correlations associated with service cost.

Although the researcher was unable to test the occupational prestige hierarchy to test hypotheses four, she did obtain information regarding the respondent's preferred next hire within the facility. The survey item stated, "Assume you had one new position available to support expanded services to clients. Please rank the following five professional types from 1 to 5, using 1 as your most preferred next hire and 5 as your least preferred next hire." RT's most frequent category was the fourth preferred next hire

(29.8%). The second highest percentage for RT is within the number one (most preferred) next hire (20.2%). See Table 15 for detailed results of respondent's preferred next hire.

Table 15

Respondents' Preferred Next Hire

	N	1 (Most) n (%)	2 n (%)	3 n (%)	4 n (%)	5 (Least) n (%)
Activity Professional	384	108 (28.1%)	43 (11.2%)	36 (9.4%)	73 (19.0%)	**124** **(32.3%)**
Occupational Therapist	364	45 (12.4%)	**151** **(41.5%)**	103 (28.3%)	50 (13.7%)	15 (4.1%)
Physical Therapist	362	**141** **(39.0%)**	79 (21.8%)	71 (19.6%)	54 (14.9%)	17 (4.7%)
Recreational Therapist	372	75 (20.2%)	60 (16.1%)	31 (8.3%)	**111** **(29.8%)**	95 (25.5%)
Speech Therapist	378	22 (5.8%)	38 (10.1%)	**125** **(33.1%)**	74 (19.6%)	119 (31.5%)

Research Question 5

What are the perceived benefits and barriers that contribute to estimated occupational value of recreational therapy practitioners to health care facilities?

Survey respondents identified their perceived benefit of each treatment service ranging from (1) *extremely* to (5) *not at all beneficial*. The following are the "extremely" and "very beneficial" results for each service professional: physical therapists (84.6%), occupational therapist (82.8%), activity professional (77.0%), speech pathologist (76.9%), and recreational therapist (55.4%). See Table 16 for further details.

Table 16

Respondents' Perceived Benefits of Treatment Services

	N	Extremely Beneficial n (%)	Very Beneficial n (%)	Somewhat Beneficial n (%)	Slightly Beneficial n (%)	Not at all Beneficial n (%)
Activity Professional	378	214 (56.6%)	77 (20.4%)	36 (9.5%)	23 (6.1%)	28 (7.4%)
Occupational Therapist	378	245 (64.8%)	68 (18.0%)	35 (9.3%)	16 (4.2%)	14 (3.7%)
Physical Therapist	377	262 (69.5%)	57 (15.1%)	25 (6.6%)	14 (3.7%)	19 (5.0%)
Recreational Therapist	375	113 (30.1%)	95 (25.3%)	88 (23.5%)	38 (10.1%)	41 (10.9%)
Speech Pathologist	377	227 (60.2%)	63 (16.7%)	43 (11.4%)	18 (4.8%)	26 (6.9%)

To further understand what benefits the administrators identified with having a LRT, an open-ended item in the survey stated, "Regardless of whether you do or do not currently employ a LRT at your facility, please identify any potential benefits you see of having a LRT on staff." A qualitative analysis was completed utilizing inner-rater reliability to verify item placement of the 250 responses (See Appendix C) within several categories: patient outcomes, financial standpoint, professionalism, activity professional reference, multidisciplinary, and negative answers. First, 141 responses referred to a wide array of patient outcomes with improved quality of life being the most frequent (n = 19) followed by increased quality/ level of patient care (n= 9) and improved functional status (n= 8). Next, administrators had the following negative comments concerning financial barriers including RT is not in the budget (n= 6), too costly (n= 7), and not billable/

reimbursable (*n*= 13). However, 3 respondents implied they could see the benefit of RT if it was billable and 3 different respondents stated RT was billable with documentation and provided revenue at their facilities. The next category identified through survey respondents was professionalism, in which the following sub-categories arose: education, training, and expanded services. Specifically, nine respondents referred to the benefit of LRTs education including references to a four-year degree, aging process, evidenced-based practice, etc. LRT being trained in a variety of areas was a frequent benefit identified by 51 respondents (e.g., assessments, documentation, individualized treatment). Also, twenty respondents commented RT expands and/or enhances the variety of activities and interventions offered to their clients. Many respondents referred to RT and its role with other health care professionals. Moreover, thirty respondents made positive and negative references to the activity department, while nineteen recognized its complementary role within the multidisciplinary team (e.g., PT, OT, and ST.) Sixteen respondents stated they could not name any benefits because they were unsure of what a LRT was or had never worked with one before. Finally, twenty-six administrators saw no benefit of a LRT at their facility.

If the respondents identified that they did not have a LRT on staff, they were automatically navigated to a series of questions related to perceived barriers. Respondents were presented with several barrier statements and had the following responses to select from: "*agree*," "*disagree*" or "*I don't know*." The following are the main results revealed for why respondents believed there may not be a LRT on staff: 41.4% of respondents did

not know if having a LRT was not warranted after a cost-benefit analysis, 69.7% agreed the budget does not permit a LRT to be on staff, 44.8% disagreed they were unsuccessful in finding an individual with the appropriate credentials, 45.5% did not know if RT was reimbursable, and 40.3% agreed RT was not needed at their particular facility. See Table 17 for detailed results.

Table 17

Respondents' Perceived Barriers of LRTs

Perceived Barriers	N	%
Not warranted after cost-benefit analysis (*n = 220*)		
Agree	80	36.4%
Disagree	51	23.2%
I don't know	91	41.4%
Budget does not permit a LRT on staff (*n* =238)		
Agree	166	69.7%
Disagree	37	15.5%
I don't know	37	15.5%
Unsuccessful finding individual w/ appropriate credentials (*n* = 201)		
Agree	33	16.4%
Disagree	90	44.8%
I don't know	78	38.8%
RT is not reimbursable (*n* = 211)		
Agree	71	33.6%
Disagree	45	21.3%
I don't know	96	45.5%
Not needed at my facility (*n* = 216)		
Agree	87	40.3%
Disagree	84	38.9%
I don't know	45	20.8%

As previous research indicates (Thorn, 1984), marketing has always been a major concern for RT. Respondents were asked to select all marketing avenues utilized for RT services. Results showed RT was marketed in the following ways: word of mouth (22.9%), brochure (21.6%), website (19.5%), professional referrals (18.2%), phone recording while on hold (8.2%), and television (2.6%). Unfortunately, the results of this study supported the RT marketing barrier, where 70.1% of respondents reported not marketing RT. See Table 18 for detailed results of marketing for all disciplines.

Table 18

Marketing Avenues of Treatment Services

Marketing Avenues of Treatment Services	N	%
Activity Services (*n* = 329)		
Word of mouth	213	64.7%
Brochure	211	64.1%
Website	157	47.7%
Professional referrals	116	35.3%
Phone recording while on hold	97	29.5%
Service is not marketed	83	25.2%
TV	17	5.2%
Occupational Therapy (*n* = 333)		
Brochure	235	70.6%
Word of mouth	227	68.2%
Professional referrals	224	67.3%
Website	187	56.2%
Phone recording while on hold	99	29.7%
Service is not marketed	55	16.5%
TV	22	6.6%

Physical Therapy (*n* = 334)		
Professional referrals	225	67.4%
Word of mouth	225	67.4%
Brochure	237	71.0%
Website	189	56.6%
Phone recording while on hold	101	30.2%
Service is not marketed	53	15.9%
TV	22	6.6%
Recreational Therapy (*n* = 231)		
Service is not marketed	162	70.1%
Word of mouth	53	22.9%
Brochure	50	21.6%
Website	45	19.5%
Professional referrals	42	18.2%
Phone recording while on hold	19	8.2%
TV	6	2.6%
Speech Therapy (*n* = 327)		
Brochure	226	69.1%
Professional referrals	218	66.7%
Word of mouth	215	65.7%
Website	184	56.3%
Phone recording while on hold	101	30.9%
Service is not marketed	59	18.0%
TV	21	6.4%

When developing the survey, the researcher was interested if respondents would identify providing RT services without having a LRT on staff. Interestingly, most respondents still identified providing RT services despite not having a LRT on staff (82.4%). In fact, 75.4% identified activity professionals providing RT services at their facility followed by volunteers (51.1%). See Table 19 for detailed results.

Table 19

Providers of RT at Respondents' Facility if no LRT on Staff

	N	%
Who provides RT if no LRT on staff (*n* = 284)		
Activity Professional	214	75.4%
Volunteer	145	51.1%
Nursing Staff	102	35.9%
Occupational Therapist	97	34.2%
Physical Therapist	73	25.7%
None of the above (no recreational therapy)	50	17.6%
Recreation Worker	42	14.8%
Other	19	6.7%
CTRS	9	3.2%
LRTA	1	0.4%

The respondents were presented with several interventions (e.g., aquatic therapy, animal-assisted therapy, etc.) and were instructed to select all professionals (e.g., activity professional, recreational therapists, physical therapist, etc.) and non-professionals (i.e., volunteers and paid non-staff) that facilitated these programs in their respective agencies. There was a total of 21 interventions divided by focus on physical wellbeing, cognitive wellbeing, emotional wellbeing and meeting multiple client needs. The interventions listed were comprised of those in which a LRT is trained to provide. Activity professionals dominated all disciplines being identified as the top facilitator for 14 interventions: active games (88.2%), exercise and movement (78.1%), outdoor adventure (90.5%), cognitive stimulation (77.1%), passive games (84.7%), reality orientation (76.3%), sensory stimulation (79.9%), expressive therapies (83.8%), humor therapy

(85.7%), relaxation therapy (75.5%), animal-assisted therapy (79.2%), horticulture therapy (85.4%), leisure education (82.6%), and therapeutic use of magic (87.4%). Thus, the activity professional was the lead facilitator for 3/ 4 physical wellbeing programs, 4/4 for cognitive wellbeing, 3/6 for emotional wellbeing and 4 /7 for providing interventions that meet multiple client needs. Nursing was identified as the most frequent facilitator of symptom management (83.1%), relapse prevention (54.7%), and behavior modification (68.1%). Therefore, leading two interventions from the multiple client needs category and one from emotional wellbeing. Physical therapist was the highest facilitator of aquatic therapy (76.8%), which represented the physical wellbeing. Social workers led the group for facilitating stress management (67.2%), coping skills (69.1%), and community reintegration (54.6%); leading two interventions from the emotional category and one from the multiple client needs category. See Appendix A for detailed results of facilitators of interventions.

The perceived replacement value of RT can be identified through respondents' (a) perceived difficulty of other professionals to provide RT services and (b) perceived overlap of other professions with RT. Perceived difficulty was measured on a five point Likert scale ranging from (1) *extremely difficult* to (5) *not at all difficult*. The following includes the combined results for (5) *not at all*, (4) *slightly*, and (3) *somewhat difficult* for other disciplines to provide RT services: activity professional (76.2%), occupational therapist (69.6%), physical therapist (58.4%), and speech therapist (43%). See Table 20

for more detailed results of respondents' perceived difficulty of other professionals providing RT services.

Table 20

Respondents' Perceived Difficulty of other Professionals Providing RT

Treatment Services	N	%
Activity Professionals (*n* = 366)		
Extremely difficult	24	6.6%
Very difficult	63	17.2%
Somewhat difficult	103	28.1%
Slightly difficult	104	28.4%
Not at all difficult	72	19.7%
Occupational Therapists (*n* = 368)		
Extremely difficult	42	11.4%
Very difficult	70	19.0%
Somewhat difficult	113	30.7%
Slightly difficult	79	21.5%
Not at all difficult	64	17.4%
Physical Therapists (*n* = 368)		
Extremely difficult	61	16.6%
Very difficult	92	25.0%
Somewhat difficult	98	26.6%
Slightly difficult	71	19.3%
Not at all difficult	46	12.5%
Speech Therapists (*n* = 367)		
Extremely difficult	92	25.1%
Very difficult	117	31.9%
Somewhat difficult	86	23.4%
Slightly difficult	48	13.1%
Not at all difficult	24	6.5%

Respondents' perceived overlap of RT with other service professionals was measured on a 5-point Likert scale ranging from (1) *complete overlap with RT* to (5) *no overlap with RT*. Results showed the following with (1) *complete*, (2) *major*, and (3) *moderate overlap* with RT: activity professionals (78.5%), occupational therapist (44.7%), physical therapist (30.5%), and speech therapist (19.9%). See Table 21 for more detailed results.

Table 21

Respondents' Perceived Overlap of Treatment Services with RT

Treatment Service	N	%
Activity Professionals (*n* = 364)		
Complete overlap with RT	31	8.5%
Major overlap with RT	117	32.1%
Moderate overlap with RT	138	37.9%
Slight overlap with RT	65	17.9%
No overlap with RT	13	3.6%
Occupational Therapists (*n* = 367)		
Complete overlap with RT	5	1.4%
Major overlap with RT	33	9.0%
Moderate overlap with RT	126	34.3%
Slight overlap with RT	137	37.3%
No overlap with RT	66	18.0%
Physical Therapists (*n* = 367)		
Complete overlap with RT	2	0.5%
Major overlap with RT	22	6.0%
Moderate overlap with RT	88	24.0%
Slight overlap with RT	148	40.3%
No overlap with RT	107	29.2%

Speech Therapists (*n* = 365)		
Complete overlap with RT	3	0.8%
Major overlap with RT	10	2.7%
Moderate overlap with RT	60	16.4%
Slight overlap with RT	112	30.7%
No overlap with RT	180	49.3%

An independent samples *t* test was calculated comparing the mean scores of difficulty and overlap variables to those facilities that do and do not have a LRT on staff. There was no statistical significance found between variables. However, mean scores revealed that those respondents who have a LRT on staff identified a lower mean score, which represents a higher difficulty rating, for activity professionals (*M* = 3.32), physical therapists (*M* = 2.83), and speech therapists (*M* = 2.33) to perform recreational therapy duties than those who did not have a LRT on staff. Those respondents who had a LRT on staff showed a higher mean score, which represents a lower difficulty rating, for occupational therapists (*M* = 3.17) to perform recreational therapist duties than those who did not have a LRT on staff. In summary, the occupational therapist was the only profession identified as being less difficult to perform RT duties by those who had a LRT on staff in comparison to those who did not have a LRT. Likewise, respondents who have a LRT on staff identified less overlap of recreational therapist scores for occupational (*M* = 3.67), physical (*M* = 3.93) and speech therapists (*M* = 4.31) compared to those who did not have a LRT on staff. Activity professional (*M* = 2.66) was the only profession identified as having more overlap with recreational therapy by those who have a LRT as opposed to those who did not.

To test hypothesis three (i.e., Respondents' who perceive RT to have a high replacement value will identify other professionals providing RT within their facilities), the researcher manipulated data in SPSS creating several subgroups. By selecting specific cases, the researcher was able to isolate each treatment services' low level of difficulty and high level of overlap to determine if these subgroups identified other professionals providing RT services. Specifically, the subgroup representing activity professionals with (4) *slightly* and (5) *not at all difficult* scores to provide RT services was analyzed with all professionals and non-professionals listed within the statement, "If you do not have a LRT on staff, who provides RT, if anyone, at your facility?" This process was employed for all four treatment services. Likewise, the same process was applied to those subgroups comprised of treatment services that were identified as having (1) *complete* and (2) *major overlap* with RT. Therefore, a total of eight runs were made to include all treatment services within low difficulty scores and high overlap scores. Frequency tests confirmed hypothesis three to be true as all eight subgroups exhibited (a) low difficulty, (b) high overlap, and c) other professionals and non-professionals providing RT services at their facility. In fact, all eight subgroups identified activity professionals as the top provider of RT ranging from 75- 90% within each subgroup. Volunteers were the next most frequent category providing RT ranging from 55-84% in each subgroup. Nursing and occupational therapists varied for the third most frequent provider of RT services ranging from 40-65%. In addition, all subgroups predominantly did not have a LRT on staff ranging from 79-86%.

The researcher also manipulated data in SPSS creating several subgroups to test hypothesis five (i.e., Those who characterize RT as an expensive service with little to no benefit will also (a) not have a LRT at their facility, (b) hire other professionals to perform RT duties, and/or (c) if they do have a LRT, they will receive a lower salary). By selecting specific cases, the researcher was able to isolate each treatment services' low beneficial scores and high service cost scores to determine if these subgroups identified other professionals providing RT services and/or if LRTs were on staff. For example, the subgroup of respondents that identified RT as (4) *slightly* and (5) *not at all beneficial* was analyzed with all professionals and non-professionals (e.g., activity professionals, OTs, PTs) listed within the statement, "If you do not have a LRT on staff, who provides RT, if anyone, at your facility?" and "Do you have a LRT on staff?" Likewise, the subgroup of respondents that identified RT as a (1) *extremely* and (2) *very expensive* service were analyzed with the other professionals providing RT. Frequency tests proved hypothesis five to be true as both the low beneficial and highly expensive subgroups identified (a) over 90% of the facilities not having a LRT on staff, (b) 60- 77% of activity professionals providing RT, and (c) 41- 52% of volunteers providing RT. Respondents who identified starting salaries for LRTs at their facility did not identify low beneficial scores. Only four respondents that perceived RT to be extremely or very expensive also provided a starting salary for LRTs, which were distributed evenly to each salary category. Therefore, salary relating to hypothesis five is inconclusive.

A crosstab Chi-square was computed between respondent's job title and RT being a beneficial service. The relation between these variables were statistically significant x^2 (4, N = 295) = 17.14, p = .002. CEO's and director's of rehab services were the least likely groups to find RT services "extremely" or "very" beneficial. Conversely, administrators followed by program directors and "other" were the most likely groups to find RT as an "extremely" or "very" beneficial service.

A crosstab Chi-square was also calculated between RT being a beneficial service and having a LRT on staff. This relationship was statistically significant x^2 (1, N = 307) = 12.12, p = .000 indicating there were more respondents who identified RT as an (1) *extremely* to (2) *very beneficial* service than rating it (3) *somewhat* to (5) *not at all beneficial* for both those facilities that did and did not have a LRT on staff.

Summary

The descriptive results identified RT being the least familiar, beneficial and utilized treatment service within this study. In addition, statistical significances were found showing that familiarity, prestige, facility profile, and perceived benefit all have implications on the existence and non-existence of LRTs being on staff. Finally, activity professionals, occupational therapists, physical therapists and speech therapists were all identified as potential competitors to LRTs as replacement values were found within each treatment service.

CHAPTER V

DISCUSSION

The purpose of this study was to survey key supervisory staff at North Carolina health care facilities to (a) identify the existence and positions that compete with recreational therapy (RT) services, and (b) understand the rationale driving health care facility decisions related to the provision of RT programs to their clients. This chapter discusses the study's limitations, conclusions and implications, and recommendations for practice and future research.

Limitations

The first limitation involved the sample. The North Carolina Board of Recreational Therapy Licensure (NCBRTL) indicated there were 596 current Licensed Recreation Therapists (LRTs) and 50 Licensed Recreation Therapist Assistants (LRTAs) in North Carolina (NC). The number of respondents who indicated they had a LRT at their facility was quite low in comparison to the entire sample. Moreover, the 58 respondents who did have a LRT on staff identified an aggregated total of 106 LRTs and 12 LRTAs working at their facilities. Although some administrators may be unaware of having a LRT at their facility, this lack of awareness cannot be assumed. In any event, a greater representation of agencies that had a LRT might have given stronger comparisons in data analysis.

A second limitation of the study is that only two agency types (i.e., skilled nursing and hospital) represented the majority of the sample at 63%. In addition, representation from the nursing home facilities was substantially larger than hospitals and few were from mental health facilities. The differences in response rate may be attributed to several factors. First, the researcher had to personally contact each facility individually by phone in order to obtain the email address for the survey. Nursing home facilities were contacted first and thus had a longer response period than mental health facilities who were contacted last. Also, the Executive Director of the North Carolina Board of Recreational Therapy Licensure stated the following regarding poor timing of the survey in relation to the mental health sample:

> The North Carolina mental health facilities may have been reluctant to complete the survey as they were under an entire revision of their RT positions due to Chapter 90 C. DHHS entered an amendment to Chapter 90 C into legislation after the licensing law was passed because of the sanctions they were receiving. This detailed them to develop a compliance plan and to be compliant by July 1, 2010. So, the timing of the survey was during the time they were revising all of their RT positions and developing a compliance plan. (B. Garrett, personal communication, July 8, 2010)

Second, much of the facility information provided by the Department of Health and Human Services (DHHS) database was incorrect especially for the mental health facilities despite being updated in January 2010. The phone numbers provided were often the wrong number, disconnected, or continued to ring. Also, the mental health facilities that were listed with the correct numbers often resulted in having to leave a voicemail. The final factor was nursing homes were the only group on the DHHS list that included

administrator's name. This was extremely helpful when calling the receptionist. Therefore, all factors may have attributed to the large amount of respondents being from the nursing home section and smaller representation from the mental health setting.

The benefit of having the administrators' name for the nursing home section also served as the third limitation for the remaining facility types included in this study. The DHHS list provides phone numbers to the facility, in which a receptionist or automated message system usually answers. The researcher often had difficulty with the receptionists of hospitals, assisted living communities, and mental health facilities being apprehensive to connect her with administrators because she did not ask for them by name. Consequently, the researcher often had to go into great detail of the nature of the call and one of the following events transpired. The receptionist would (a) make the decision for the administrator if they would be interested or not, (b) take down a written message, (c) provide their own email address to forward the message personally, (d) transfer the researcher to the wrong department, or (e) connect the researcher to the appropriate administrator. Thus, the response rate may have been negatively affected by not having the administrator's name and direct number.

A fourth limitation of the study involved the distribution of the survey via email. The web-based survey has several advantages over mailing, especially when contacting people at this high of rate. Almost all administrators preferred the web-based survey; however, considering the sample at hand, administrators are overwhelmed with emails on a daily basis. The researcher's email could have easily been deleted, lost in a mass amount of emails, or the administrator may have had a lack of motivation to respond to

the survey when viewing their amount of work-related emails. In addition, some of the email attempts to send the electronic surveys were denied because of strong facility firewalls prohibiting unrecognized email addresses. Therefore, the implications of the web-based survey on response rate are undetermined.

A fifth limitation was the researcher's low reliability score for her self-designed multi-item prestige scale. Although literature helped construct variables, low reliability prohibited the researcher from further examination of the occupational prestige levels within each profession as a single construct. Prestige comprised two of the five research questions so data analysis had to be adjusted to examine individual prestige items one by one. Therefore, theoretical advancement of a prestige scale is not supported by this study.

The final limitation is relying on the honesty of respondents' self-reporting in the survey. Even though the respondents are informed the survey is confidential and anonymous, it cannot be assumed that respondents are being entirely honest and accurate. Respondents may try to answer items in a safe manner and try to appease the researcher. Therefore, accuracy of the results could be limited.

Conclusions and Implications

RT was identified as the least familiar treatment service to health care administrators in this study. Results showed those facilities that had a LRT on staff had significantly more familiarity with RT services than those who did not have a LRT on site; thus, confirming hypothesis one. Moreover, further exploration indicated that those who indicated being "extremely" and "very familiar" with RT were not actually as familiar with RT as they perceived. For example, although these respondents indicated

high familiarity, many thought therapeutic recreation was offered only in the community and that RT was mainly designed to provide fun activities for clients in their down time and did not know RT was medically prescribed and required licensure in North Carolina. It is evident that even those respondents who feel they have a high level of familiarity with RT do not fully understand the profession. Thus, in accordance with the behavioral goals principle of Social Marketing Theory (Morris & Clarkson, 2009), a change in administrators' knowledge and attitudes toward RT is warranted. It is obvious from these results that administrators' familiarity with RT is lacking and this lack of familiarity could negatively impact the inclusion of RT services in health care facilities. New marketing efforts need to target both administrators of facilities that do and those that do not have a LRT on staff, as neither seem to have a thorough understanding of LRTs.

RT was identified by survey respondents as the least utilized service in all facility types and units that make up the facility. Administrators revealed how uninformed they truly are of the capabilities of LRTs. Sixteen survey respondents could not answer what the benefits are of having a LRT because they were unaware of what a LRT is. The majority of administrators responded "I don't know" to two of the five barrier items in the survey: "RT was not warranted after cost-benefit analysis" and "RT is not reimbursable". In addition, 20.8% of those respondents who did not have a LRT did not know if a LRT was needed at their facility, while 38.8% did not know if the facility was unsuccessful finding an individual with appropriate credentials. An explanation for why administrators did not know if RT was warranted after cost-benefit analysis is because a cost-benefit analysis was never conducted. Forty respondents who currently do not have a

LRT on staff did not know if a LRT had previously worked there. Not only did administrators demonstrate they are uninformed, but many do not take RT seriously as indicated by the following results. The survey items that addressed potential overlap of RT with other health care services as well as potential difficulty to perform RT duties did reveal a high replacement value of RT viewed by administrators indicating that RT could be easily replaced by other professionals. Arguably, one of the most professionally damaging results is that 234 administrators admitted not having a LRT and indicated that both other professionals and non-professionals provided RT at their facility inferring that RT education and credentials are not needed to provide RT. Over two-thirds of respondents in this sample indicated that activity professionals, who do not need a college degree, provide RT at their facility. However, the most disturbing result is that 51% of administrators identified that volunteers provide RT services. In summary, many administrators are not hiring LRTs because they are unsure or uninformed about the RT profession.

One rationale for administrators from long term care (LTC) and assisted living (AL) communities being less likely to hire a LRT may be due to the reliance on activity professionals to meet the greater need of the geriatric populations. This could explain why activity professionals received higher scores than RT on the benefit item because over half (58.4%) of the survey respondents represent LTC and AL communities. A major conclusion derived from results is that many of the AL communities do not deem RT as an appropriate service. Successful activity professionals do provide well-rounded programs, but the addition of a LRT can produce therapeutic outcomes that extend further

than distraction and engagement techniques. Therefore, the researcher suggests not eliminating the activity professional, but adding LRTs because although activities are mandated, not all residents attend activity programs. In fact, the residents that usually need activity stimulation the most do not attend because they are lower functioning or too depressed to participate. LRTs can provide one to one treatments services to work with residents individually on skilled, memory care and AL units.

Despite administrators' viewpoints, the researcher believes many assisted living residents could greatly benefit from RT. As the geriatric population begins to grow (Occupational Outlook Handbook, 2010), transitions within long term care are often delayed due to limits of beds on skilled and memory care units. Thus, a greater number of lower functioning residents comprise the AL unit. RT can also assist in carrying out resident goals from OT, PT, and ST as well.

Physician referrals were the top client recommendations for RT, PT, OT and ST. However, physician referrals were over 60% more frequent for PT, OT and ST than for RT. This result suggests how displaced RT is from physicians. Physicians need to be at the forefront of marketing initiatives for RT. Physicians play a critical role within health care and gaining their acknowledgement and referral could enhance RT's professional image. For example, the interaction physicians have with other health care professionals (e.g., nursing, case managers), who also have the potential to write client referrals, cannot be overlooked. If nurses and case managers converse with physicians who refer RT, they may be more inclined to further understand RT and even more so, potentially write referrals for RT. Also, patient and caregiver requests are usually confirmed or denied by

the physician. Overall, there could be a stream of positive events that occur if RT properly educate and market the service to physicians. The best case scenario is once physicians "buy into" the RT philosophy and client benefits; they will begin referring and hopefully advocating for the RT profession. Physicians advocating for the RT field could have tremendous implications that would not be possible otherwise because RT does not have the member support or money to advocate on the level physicians could. However, marketing and educating physicians needs to be taken with caution and extreme care, as RT does not have the evidence-based practice support as other health care professions (Austin, 2009). Therefore, more RT research and clinical guidelines need to be established by the RT academic, scholar, and practicing community to establish a more evidence-based approach to RT. This may be the best approach when considering marketing the RT profession to physicians.

Analysis of perception variables relating to having a LRT on staff indicated a statistical significance between RT being a usual part of the interdisciplinary team, RT providing recreation-based interventions, and RT being an inexpensive service. The interdisciplinary team recognition by administrators who hire LRTs is a positive recognition of professionalism. However, RT being recognized as providing recreation-based interventions and being an inexpensive service may have positive and negative implications. Recreation-based interventions through evidenced based practice produce patient outcomes, but are widely not viewed as being medically-necessary. Typically, being recreation based is interpreted as being diversional. Also, the fact that RT is seen as inexpensive is a positive marketing selling advantage, but also places CTRSs and LRTs

at a disadvantage of being underpaid for their education, credentials and experience. On a side note, those prestige variables that were not statistically significant (i.e., medically prescribed, licensure, etc.) are not being acknowledged by administrators. As evidenced by this study, RT is likely not being recognized as a medically prescribed therapy due to the lack of professional referrals within facilities. A rationale for the licensing issue is that credentials are not marketed well enough in those facilities that do and do not have LRTs. First, 21.5% of respondents did not know North Carolina requires the individual to be licensed to practice RT. Also, nine respondents who did not have a LRT on staff indicated having a CTRS. A reasonable explanation for this is administrators are most likely not recognizing that CTRSs are also LRTs in NC. Nine may seem like a small number, but considering only 58 facilities had LRTs, it could have significant implications. Therefore, not only is RT struggling with marketing to outside facilities but also within the facilities in which LRTs are hired.

When asked which service respondents prefer to hire next, RT was most frequently ranked as the fourth and fifth consideration. However, 20 of the respondents identified RT as the most preferred hire. There were conflicting data when analyzing this result, as skilled nursing facilities were identified as the majority who selected RT as their most preferred next hire; however, skilled nursing was also identified as the least likely facility type to hire LRTs. This suggests that skilled nursing is interested in hiring LRTs, but might not have the financial resources to support expanded service; therefore, explaining the large number of activity professionals and volunteers represented within the study.

Results show activity professionals are a major competitor to LRTs. Activity professionals who received the lowest ratings for educational rigor of all disciplines were identified as having the most overlap with RT ("moderate" to "complete," 78.5%) and the least amount of difficulty in substituting for RT ("not at all difficult" to "somewhat," 76.2%). Also, 75.4% of respondents who identified not having a LRT on staff indicated that activity professionals provide RT services at their facility. A rationale explanation for such results may be administrators perceive these professions to be interchangeable as many LRTs are recruited for activity director positions. Also, of the 250 respondents who chose to answer the open-ended item of the potential benefits of having a LRT on staff, 12% made a positive or negative comparison to activity professionals. Finally, activity professionals were identified as the leading professional for facilitating programs and interventions, where they topped 14 of the 21 interventions listed in the survey. However, the fact that activity professionals led certain interventions (i.e., outdoor adventure, animal assisted therapy) more frequently than other therapies indicates that administrators may not understand what these interventions entail. Outdoor adventure groups are much more than providing an activity outside and likewise, animal assisted therapy does not include having pet visits on the unit. The administrators did identify the education differences between LRTs and activity professionals, where the majority (37%) perceived activity professionals' education to be slightly rigorous and LRTs' education to be somewhat rigorous (32.2%). Although the majority of respondents perceive LRTs education to be somewhat and very rigorous (68.4%), the recreation background may have negative implications. Respondents may view the RT education as somewhat

rigorous; however, insignificant in comparison to medical degrees received by physical, speech and occupational therapies.

Occupational, physical, and speech therapies also were shown to compete with RT. All received an overall positive perception and were well represented within the facility types and units. Replacement values for RT were found to be high as many administrators reported the former three therapies to be "not at all" to "somewhat difficult" to provide RT: OT (69.6%), PT (58.4%), ST (43%). Also, "moderate" to "complete" overlap with RT was also identified: OT (44.7%), PT (30.5%), and ST (19.9%). Rationale for these therapies being recognized as competitors to RT could be that recreation and play is sometimes integrated within the treatment services. Conversely, recreation, leisure, and play are the treatment tools by which RT thrives. On a side note, other minor competitors with providing many of the interventions were identified as nurses, social workers and volunteers.

According to survey respondents, RT was the least beneficial and least marketed treatment service. The lack of marketing could be the overarching problem by which such low scores were received in prestige, perceived familiarity, perceived benefits, etc. RT was the least marketed treatment service; however, 162 respondents responded to this item, where only 58 identified having a LRT at their facility. Rationale for this inconsistency may be that respondents did not properly read the top line stating "service is not marketed" and mistook it for "service is not offered." As activity professionals, and PT, OT, and ST are all well represented within all facility types and units, it may be attributed to their top marketing avenues: brochures, websites, and professional

references. Websites are a major avenue that needs to be more actively pursued. Health care facilities that do have RT services either do not market RT on their website or is difficult to find. The importance of professional references was discussed in research question #2.

Over half (51%) of the starting salaries reported for LRTs by survey respondents in this current study ($20- 30,999) was consistent with Hinton's findings ten years ago, in which the majority of RTs reported their salary between $20- 29,000 (*n* = 117). In fact, administrators reported the most frequent starting salary for LRTs fell within the $26-30,999 range. Such low LRTs salaries may contribute to the negative and false perceptions of RT held by administrators. As Hinton (2000) indicated in her study "people who have low or moderately high salaries exhibit less prejudice toward RT than those who have moderate to high salaries" (p. 120). As the OOH (2010-2011) revealed the average salary for health care administrators in May 2008 was $80, 240 and it can be assumed hospital CEO's receive more than that.

Overall, RT was negatively perceived by the respondents on the basis of being less familiar and underutilized service compared to other health care professionals. This is especially concerning because these results reflect administrative views of RT in North Carolina, which received positive national recognition as the number one state for RT (Austin, 2007). In his blog, Austin (2007) identified that North Carolina was the number one state for recreational therapy for the following reasons. First, he remarked on North Carolina's rich heritage in RT by naming numerous distinguished professionals from or working within the state who have made significant contributions to RT at large (i.e.,

Dave Park, Peg Connolly, Ray West, Thom Skalko, Carmen Russoiello, Pam Wilson). Many had at one time served as the American Therapeutic Recreation Association (ATRA) president. In addition, Austin (2007) established the high quality RT programs at both the University of North Carolina Hospitals and Wake Forest University Baptist Medical Center. Likewise, he identified the outstanding academic programs for RT at East Carolina University, the University of North Carolina at Greensboro, the University of North Carolina at Wilmington, and Western Carolina University. He also mentioned the North Carolina Recreational Therapy Association was "known throughout the nation as a leader among state RT membership organizations" (Austin, 2007). He concluded with a reference to legislation, in which North Carolina was the second state to require licensure to practice RT.

If such poor results were gathered from such a highly regarded state, it is worrisome to think how the remaining states would be perceived considering the majority do not require licensure to practice and lack the numbers for academic program opportunities to prepare RT professionals that North Carolina provides. On a positive note, many of these perceptions can be changed as administrators demonstrate being unfamiliar with the profession. Therefore, with the proper marketing and education efforts, the RT image may be improved. The following sections include such recommendations.

Future Research Recommendations

This study explored a research area that has never been investigated. Previous studies (Hinton, 2000; Smith et al., 1992) have laid the foundation for researching the

allied health professional perspective of RT services; however, this is the first study to examine administrative opinions of competing health professionals, specifically RT. Results from all three studies show a major concern in the perception of RT services and warrants more research investigating RT's professional image and status.

Since this research was examining a new line of study, replication of this research is necessary with some recommendations. The following items should be considered to include in the survey. First, the "level of education" should be an item within the respondent's demographics section of the survey. Including this item could provide further insight to determine if those who received a higher education or a certain type of degree would express better knowledge of the treatment services (e.g., familiarity, medically prescribed therapies, etc.). Usually a higher education level is associated with administrative figures (e.g., CEO, Vice Presidents, etc.), but this cannot be assumed.

Questions relating to evidenced-based practice (EBP) should be added to the section of the survey concerning opinions of professional services. Evidence-based practices have been a professional trend many fields are emphasizing and it would be beneficial to obtain the administrator's point of view regarding RTs use of EBP. More specifically, add survey items that identify what treatment services administrators' view as being evidence-based and the level of importance of EBP at their respective facilities.

In order to better understand the implications of survey respondents' opinions of RT services, including a question such as, "Are you directly involved in the hiring process of LRTs?" would be helpful. Such information could determine how variables

function as drivers to hiring a LRT. Moreover, future research could report how administrative opinions negatively of positively affect the hiring decision of LRTs.

Another addition to the survey that would be valuable is directly asking the respondents their opinions of prestige related to each treatment service using a 5-point Likert scale ranging from (1) *extremely prestigious* to (5) *not at all prestigious*. This could at least serve as a back-up if unreliable ratings occur in the development of future prestige scales. Further reevaluation and implementation of potential prestigious questions is warranted.

The final addition recommended to include in the survey relates to current reimbursable services at the administrator's facility. The researcher could not find literature that reveals the amount of facilities whose RT services are reimbursable. Due to the strong push and effort put toward gaining reimbursable status for RT, it is predicted that a low amount of facilities actually do. It would be informative to know the demographics consistent with reimbursable services (i.e., facility type, clients served). Overall, taking the suggested additions into consideration, future research using these survey items needs to be replicated with a larger sample of mental health facilities.

The relationship between perceived cost and benefit of health care services needs to be further investigated as results differentiated. Specifically, activity professionals were identified as the cheapest service, but more beneficial than RT; thus, showing a negative relationship between the variables. However, the perceived cost and benefit of PT, OT, and ST had a positive relationship, in which both were located in the "extremely" or "very" categories.

The researcher learned that most of the nursing home administrators had mentioned getting the survey to them before the North Carolina Health Care Facilities Association (NCHCFA) conference began. The NCHCFA includes more than 380 licensed nursing homes in North Carolina (NCHCFA, 2010). This would be a great location to easier access administrators for future survey research and could eliminate much of the hassle discussed in the methodology and limitations section of contacting administrators via phone or email. In addition, having an informational booth on RT or even better, a conference session related to why nursing home administrators should invest in RT would be a great marketing avenue.

Finally, a stronger rapport with physicians is needed for the advancement of RT. Therefore, RTs need to collaborate with physicians to perform research. Not only does this expose physicians to patient outcomes and evidence-based practice interventions, but it also provides an opportunity for disseminating knowledge to other disciplines. In cases where it is not feasible to conduct research with a physician, it would be incumbent on the LRT to make sure physicians and other decision-makers are provided with current and relevant research involving the benefits of RT on a regular basis.

Recommendations for Practice

The first and most important recommendation for practitioners is the importance of being proactive with marketing the RT profession. As a RT practitioner, maintaining certification can be achieved through several avenues, such as attending classes, conferences, and/or publishing articles. However, the major flaw of this process is that RT is only marketing to itself (i.e., presenting at RT conferences, publishing in RT

journals). Obviously, reading RT journals and attending RT conferences are professionally beneficial, but this information needs to be disseminated into other disciplines. Therefore, if a practitioner is seeking the publishing route to gain CEU's, they need to consider submitting to well-established journals outside of RT. Likewise, RT practitioners need to present at conferences outside of RT. In addition, it would be beneficial for practitioners to take classes to become certified in a related RT intervention such as becoming a Pet Partner to provide Animal Assisted Therapy, a Laughter Leader, Aquatic Therapist, etc. All of these avenues assist the practitioner in maintaining credentials while contributing to a more professional image for the field.

As a long-going trend, many CTRSs and/or LRTs are becoming activity directors. This event is only negative if the CTRS does not take advantage of educating the administrator of how a RT program can be integrated within the facility. Moreover, this is the perfect opportunity to create a RT program that works with the activity professionals instead of working as an activity professional. It is a discredit to the education and skills CTRSs possess to not provide RT to clients. As the activity director, RT may be able to set higher standards and start hiring more CTRSs within the facility. Subsequently, this provides the facility with a marketing advantage of licensed and certified professionals treating their residents.

Another marketing recommendation is posed for the NCTRC, ATRA and/or NTRS to collaborate on having RT ambassadors whose main role would be marketing RT services to health care facilities. The ambassador's role could also extend to presenting at conferences as well, but this would be a minor task. Therefore, much like

pharmaceutical companies who send a representative to facilities to advertise their drug, a CTRS and/or LRT could provide presentations for physicians and administrators within various health care facilities. It may even be of interest to collaborate with JCACHO. Moreover, since they are a health care facility accrediting body, they are often visiting these sites. This would be a convenient and accessible way to present information to administrators. In addition, having a JCACHO accreditor, which is often a health care professional (e.g., nurse, physician), assist with the presentation could have enormous benefits as well.

The information gained from respondents in accordance with the Social Marketing Theory allows researchers to "learn from past lessons and build upon a common experience base" (Sutton, 1996, p. 62). Therefore, the researcher summarizes the following Social Marketing Theory (Morris & Clarkson, 2009) framework for RT based on the results of this study. First, the "behavior goal" is to increase the number of facilities who have LRTs. Such a task requires sufficient "customer insight," in which the foundation has been provided by this study. (i.e., what are the administrators' perceived benefits/barriers, what is the competition, who influences them, how should the audience be segmented, etc.). As this study revealed, there are differences within administrative perceptions between facility types and therefore RT needs to "segment" this market appropriately. For example, a stronger emphasis should be placed on the differences between RT and activity professionals when marketing to skilled nursing facilities as opposed to hospitals. Results from this study also show "competition" is found with activity professionals, occupational, physical and speech therapists. The "exchange" of

money for RT service is the goal, in which the approach must be customer-based. In this case, our customers (administrators) are primarily conservative expressing many financial barriers with RT, which are largely untrue as recreational therapists are resourceful and creative when working with budgets. Finally, the "intervention mix" of product (RT is the product), price (inexpensive treatment; low salary compared to other health professions), place (heath care facilities) and promotion (presenting at health care conferences, RT ambassadors) need to be integrated.

Summary

In summary, LRTs were absent from many of the health care facilities included in this study. The results revealed familiarity, prestige, and competition all impacted having a LRT on staff. Since the study presents a new concept, this research can be utilized as a framework for future studies. Overall, the RT profession needs to continue surveying various populations (i.e., general population, physicians, administrators) to raise awareness to the future direction of RT and be proactive on marketing approaches.

REFERENCES

The American Heritage® Dictionary of the English Language, Fourth Edition. Assisted living (n.d.), Retrieved July 7, 2010, from http://dictionary.reference.com/browse/assisted+living

American Occupational Therapy Association. *Definition of occupational therapy practice for the AOTA model practice act*. Retrieved November 5, 2009, from http://www.aota.org/ Practitioners/Advocacy/State/Resources/PracticeAct/36437.aspx.

American Speech-Language-Hearing Association. (2009). *Fact sheet: Speech-language pathology: (Nature of the work)*. Retrieved November 5, 2009, from http://www.asha.org/careers/professions/slp.htm.

American Therapeutic Recreation Association. *Recreational therapy: A cost-beneficial option*. Retrieved October 1, 2009, from http://www.atra-online.com/.

Austin, D. (2007, April 5). *Is North Carolina the Number One State for RT?* Retrieved October 5, 2009, from http://www.rt-blog.blogspot.com/.

Austin, D. (2009). *Therapeutic Recreation: Processes and Techniques*. 6th ed. Champaign, IL: Sagamore Publishing.

Barker, S B., & Dawson, K. S. (1998). The effects of animal-assisted therapy on anxiety ratings of hospitalized psychiatric patients. *American Psychological Association, 49*, 797-801.

Barnett, R. (1975). Sex differences and age trends in occupational preference and occupational prestige. *Journal of Counseling Psychology*, *22*(1), 35-38.

Bright, A. (2000). The role of social marketing in leisure and recreation management. *Journal of Leisure Research*, *32*(1), 12-17.

Buettner, L. (2001). *Interdisciplinary care*. *Therapeutic recreation in the nursing home: reinventing a good thing*. Retrieved July 10, 2010, from http://www.recreation therapy. com/articles/gjn-sue.htm

Buettner, L., Cummins, P., Giordano, J., Lewis, J., Lynch, C., Peruyera, G., & Siegel, J. (2008). *Recreational Therapy for the Treatment of Depression in Older Adults: A Clinical Practice Guideline*. Weston, MA: Weston Medical Publishing.

Buettner, L., & Ferrario, J. (1997). Therapeutic recreation-nursing team: A TR intervention got nursing home residents with dementia. *Annual in Therapeutic Recreation*, *7*, 21-28.

Carruthers, C., Hood, C., & Parr, M. (2005). Research update: The power of positive psychology. *Parks & Recreation*, *40*(1), 30-38.

Centers for Medicare and Medicaid Services. (2006). *Medicare Benefit Policy Manual, Chapter* 2- *Inpatient Psychiatric Hospital* Services. Retrieved November 11, 2009, from http://www.cms.hhs.gov/NursingHomeQualityInits/20_ NHQIMDS20.asp#TopOfPage.

Centers for Disease Control and Prevention. (2009). Retrieved July 6, 2010, from http://www.cdc.gov/obesity/data/trends.html#State.

Corbett, B. (1998). *More than a game: A new focus on senior activity services.* State College, PA: Venture Publishing, Inc.

Coyle, C., Kinney, W., Riley, B., & Shank, J. (1991). *Benefits of therapeutic recreation: A consensus view*. Ravensdale, WA: Idyll Arbor, Inc.

Cozart, E., & Evashwick, C. (1978). Developing a recreational program for patients in a rural nursing home. *Public Health Reports*, *93*(4), 369-374.

Dillman, D. (2000). *Mail and internet surveys: The tailored design method*. New York, NY: John Wiley & Sons, Inc.

DiStasio, S.A. (2008). Integrating yoga into cancer care. *Clinical Journal of Oncology Nursing*, *12*(1), 125-130.

Dixon, C. Therapeutic Recreation Directory. *Definitions of Recreational Therapy*. Retrieved July 7, 2010, from http://www.recreationtherapy.com/define.htm.

Doyle, K.W., Wolchik, S.A., Dawson, M.S., & Sandler, I.N. (2003). Positive events as a a stress buffer for children and adolescents in families in transition. *Journal of Clinical Child and Adolescent Psychology*, *32*, 536-545.

Edward, C. (1998). Marketing the role of recreation therapists among interdisciplinary members. *Global Therapeutic Recreation Journal*, 5, 53-66.

Falk-Kesller, J., & Ruopp, P. (1993). Prestige and occupational therapy in mental health. *Occupational Therapy in Mental Health*, *12*(3), 55-67.

Furnham, A., Pendleton, D., & Manicom, C. (1981). The perception of different occupations within the medical profession. *Social Science & Medicine*, *15,* 289-300.

George, D., & Mallery, P. (2003). *SPSS for Windows step by step: A simple guide and reference. 11.0 update* (4th ed.). Boston: Allyn & Bacon.

Hemingway, J.L. (1987). *Building a philosophical defense of therapeutic recreation: The case of distributive justice*. Old Dominion University. 1-16.

Hinton, J. (2000). Looking up from the bottom of the barrel? Examining occupational prejudice toward recreational therapy. Unpublished doctoral dissertation, Clemson, SC.

Hutchinson, S.L., Loy, D.P., Kleiber, D.A., & Datillo, J. (2003). Leisure as a coping resource: Variations in coping with traumatic injury and illness. *Leisure Sciences*, *25,* 143-162.

Kaplowitz, M., Hadlock, T., & Levine, R. (2004). A comparison of web and mail survey response rates. *Public Opinion Quarterly*, *68*(1), 94-101.

Legg, T., Nazarchuk, S., & Adelman, D. (2010). The recreational therapists versus the certified activity director: Which professional receives fewer deficiencies in long-term care facilities? *American Journal of Recreational Therapy*, *9*(1), 7-12.

Morris, Z. S., & Clarkson, P. J. (2009). Does social marketing provide a framework for changing healthcare practice? *Health Policy*, *91*(2), 135-141.

Move Forward PT. *Frequently asked questions*. Retrieved November 5, 2009, from http://www.moveforwardpt.com/faq/.

Nation, J., Benshoff, J., & Malkin, M. (1996). Therapeutic recreation programs for adolescents in substance abuse treatment facilities. *Journal of Rehabilitation*, *62*(4), 10-16.

National Association of Activity Professionals. *Standards of practice: Definition of activity services*. Retrieved October 10, 2009 from, http://www.thenaap.com/files/ Definition% 20of%20Activity%20Services.pdf

National Center for Complementary and Alternative Medicine (NCCAM), (2010).*What is CAM?* Retrieved July 7, 2010, from http://nccam.nih.gov/health/whatiscam.

National Certification Council for Activity Professionals (2010). *Certificatio*n. Retrieved July 24, 2010, from http://www.nccap.org/certification/levels/aac.shtml.

National Council for Therapeutic Recreation Certification (2009). *Why hire a CTRS. Why become a CTRS.* [Brochures]. Retrieved July 7, 2010, from http://www.nctrc.org/ standards andpublications.htm.

National Council for Therapeutic Recreation Certification (2009). *New Application. Academic and Equivalency Paths.* Retrieved July 24, 2010, from http://www.nctrc.org/newapplication.htm.

North Carolina Department of Health and Human Services. *Licensed Facilities*. Retrieved January 15, 2010, from http://www.ncdhhs.gov/dhsr/reports.htm.

North Carolina Health Care Facilities Association. (2010). *About us*. Retrieved July 15, 2010, from http://www.nursinghomesnc.com/about-us/.

Pacific Retirement Services, Inc. (2010). *Continuing care retirement communities.* Retrieved July 10, 2010, from http://www.retirement.org/ccrc.htm.

Payscale Research Center. *Recreational Therapist*. Retrieved July 5, 2010, from http://www.payscale.com/research/US/Job=Recreational_Therapist/Hourly_Rate.

Rosoff, S., & Leone, M. (1991). The public prestige of medical specialties: Overviews and undercurrents. *Social Science and Medicine, 32*(3), 321-326.

Rudnick, A. (2005). Psychiatric leisure rehabilitation: Conceptualization and illustration. *Psychiatric Rehabilitation Journal, 29*(1), 63-65.

Selman, C.R., & Land, K.B. (1998). Why you still need certified activity professionals. *Long term Care Management, 47*(11), 44-46.

Shortell, S. (1974). Occupational prestige differences within the medical and allied health professions. *Social Science & Medicine, 8*, 1-9.

Smith, R. W., Perry, T. L., Neumayer, R. J., Potter, J. S., & Smeal, T. M. (1992). Interprofessional perceptions between therapeutic recreation and occupational therapy practitioners: Barriers to effective interdisciplinary team functioning. *Therapeutic Recreation Journal, 26*(4), 31-42.

Stumbo, N., & Peterson, C. (2004). Therapeutic recreation program design: Principles and Procedures. San Francisco, CA: Pearson Education, Inc.

Sutton, S. (1996). The role of theory in social marketing. *Social Marketing Quarterly, 3*(1), 62-63.

Thompson, G.T. (2009). Reimbursement: Surviving prospective payment as a recreational therapy practitioner. In N. Stumbo, Professional Issues in Therapeutic Recreation (pp. 307-323). Sagamore Publishing.

Thorn, B. E. (1984). Marketing therapeutic recreation services. *Therapeutic Recreation Journal*, *18*(4), 42-47.

Uniack, A. (2005). *Documentation in a SNAP for activity programs*. San Anselmo, CA: S.N.A.P., Inc.

United States Department of Labor. *Occupational Outlook Handbook*. (2010-2011). Retrieved July 7, 2010, from http://www.bls.gov/oco/.

Williams, R., Barrett, J., Vercoe, H., Maahs-Fladung, C., Loy, D., & Skalko, T. (2007). *Effects of recreational therapy on functional independence of people recovering from stroke*. Retrieved July, 23 2010, from http://findarticles.com/p/articles/mi_qa3903/is_200710/ai_n24393810/.

World Health Organization. Mental Health Department. (1999). *World Health Organization Quality of Life- Annotated Bibliography*. Retrieved June 9, 2010, from http://depts.washington.edu/yqol/docs/WHOQOL_Bibiliography.pdf.

Zhou, X. (2005). The institutional logic of occupational prestige ranking: Reconceptualization and reanalyses. *American Journal of Sociology, 111*(1), 90-140.

APPENDIX A. TABLES

Table A1.

Facilitators of Activities, Therapies and Programs: Focus on Physical Wellbeing

	AP	AT/ MT	OT	PT	RT	SW	ST	NS	PNS	V	*N*
Active Games	**88.% (268)**	5.9% (18)	32.6% (99)	23.7% (72)	17.1% (52)	11.5% (35)	12.5% (38)	26.0% (79)	11.2% (34)	60.9% (185)	304
Aquatic Therapy	26.% (18)	0.0% (0)	30.4% (21)	**76.% (53)**	7.2% (5)	1.4% (1)	0.0% (0)	5.8% (4)	11.6% (8)	4.3% (3)	69
Exercise & Movement	**78.% (242)**	2.9% (9)	65.2% (202)	72.3% (224)	12.9% (40)	4.8% (15)	11.9% (37)	44.2% (137)	10.6% (33)	32.6% (101)	310

Outdoor Adventure	**90.% (210)**	1.7% (4)	21.6% (50)	25.4% (59)	12.5% (29)	10.8% (25)	4.3% (10)	23.3% (54)	9.9% (23)	43.5% (101)	232

Note: AP= Activity Professionals, AT/MT= Art/Music Therapist, OT= Occupational Therapist, PT= Physical Therapist, RT= Recreational Therapist, SW= Social Worker, ST= Speech Therapist, NS= Nursing, PNS= Paid Non-Staff, V= Volunteer, *N*= total sample size

Table A2.

Facilitators of Activities, Therapies, and Programs: Focus on Cognitive Wellbeing

	AP	AT/MT	OT	PT	RT	SW	SP	NS	PNS	V	*N*
Cognitive Stimulation	**77.1% (242)**	4.5% (14)	54.8% (172)	32.2% (101)	15.3% (48)	39.8% (125)	54.1% (170)	53.5% (168)	8.6% (27)	34.4% (108)	314
Passive Games	**84.7% (250)**	4.1% (12)	27.8% (82)	17.6% (52)	13.9% (41)	11.9% (35)	15.9% (47)	30.5% (90)	6.4% (19)	43.1% (127)	295
Reality Orientation	**76.3% (209)**	3.3% (9)	49.3% (135)	36.5% (100)	14.6% (40)	45.6% (125)	44.5% (122)	60.2% (165)	5.8% (16)	28.1% (77)	274
Sensory Stimulation	**79.9% (238)**	5.4% (16)	54.4% (162)	36.6% (109)	14.4% (43)	23.5% (70)	36.6% (109)	48.0% (143)	7.0% (21)	35.9% (107)	298

Note: AP= Activity Professionals, AT/MT= Art/Music Therapist, OT= Occupational Therapist, PT= Physical Therapist, RT= Recreational Therapist, SW= Social Worker, ST= Speech Therapist, NS= Nursing, PNS= Paid Non-Staff, V= Volunteer, *N*= total sample size

Table A3.

Facilitators of Activities, Therapies, and Programs: Focus on Emotional Wellbeing

	AP	AT/MT	OT	PT	RT	SW	SP	NS	PNS	V	*N*
Behavior Modification	50.4% (139)	4.3% (12)	34.1% (94)	27.5% (76)	13.4% (37)	64.5% (178)	27.5% (76)	**68.1% (188)**	6.9% (19)	6.2% (17)	276
Coping Skills	45.0% (127)	3.2% (9)	37.2% (105)	25.5% (72)	12.8% (36)	**69.1% (195)**	25.9% (73)	55.0% (155)	7.8% (22)	10.3% (29)	282
Expressive Therapies (music/art/dance)	**83.8% (218)**	9.2% (24)	14.6% (38)	9.6% (25)	16.2% (42)	11.2% (29)	8.5% (22)	23.1% (60)	10.0% (26)	32.7% (85)	260
Stress Management	50.2% (118)	7.2% (17)	18.7% (44)	17.4% (41)	14.5% (34)	**67.2% (158)**	12.8% (30)	50.6% (119)	8.9% (21)	12.8% (30)	235

Humor Therapy	**85.7% (168)**	5.1% (10)	14.8% (29)	12.8% (25)	14.8% (29)	21.9% (43)	8.2% (16)	29.1% (57)	8.7% (17)	36.7% (72)	196
Relaxation Therapy	**75.5% (163)**	6.9% (15)	24.5% (53)	21.8% (47)	14.8% (32)	25.9% (56)	8.3% (18)	36.1% (78)	10.2% (22)	23.1% (50)	216

Note: AP= Activity Professionals, AT/MT= Art/Music Therapist, OT= Occupational Therapist, PT= Physical Therapist, RT= Recreational Therapist, SW= Social Worker, ST= Speech Therapist, NS= Nursing, PNS= Paid Non-Staff, V= Volunteer, *N*= total sample size

Table A4.

Facilitators of Activities, Therapies, and Programs: Focus on Multiple Client Needs

	AP	**AT/MT**	**OT**	**PT**	**RT**	**SW**	**SP**	**NS**	**PNS**	**V**	***N***
Animal Assisted Therapy	**79.% (190)**	0.8% (2)	4.6% (11)	4.2% (10)	12.5% (30)	6.3% (15)	1.3% (3)	13.3% (32)	5.0% (12)	54.2% (130)	240
Community Reintegration	47.2% (102)	2.3% (5)	47.2% (102)	39.4% (85)	12.5% (27)	**54.6% (118)**	24.1% (52)	28.7% (62)	5.6% (12)	12.0% (26)	216
Horticulture Therapy	**85.4% (169)**	1.5% (3)	14.1% (28)	7.1% (14)	16.7% (33)	1.5% (3)	1.5% (3)	6.1% (12)	3.0% (6)	37.9% (75)	198
Leisure Education	**82.6% (157)**	4.7% (9)	16.3% (31)	6.8% (13)	18.4% (35)	14.2% (27)	2.6% (5)	14.2% (27)	4.2% (8)	25.8% (49)	190

Relapse Prevention	24.1% (33)	1.5% (2)	40.9% (56)	38.0% (52)	12.4% (17)	49.6% (68)	24.8% (34)	**54.7% (75)**	6.6% (9)	6.6% (9)	137
Symptom Management	13.4% (27)	2.0% (4)	46.3% (93)	47.8% (96)	9.0% (18)	32.3% (65)	31.8% (64)	**83.1% (167)**	7.5% (15)	4.0% (8)	201
Therapeutic Use of Magic	**82.4% (42)**	9.8% (5)	3.9% (2)	2.0% (1)	15.7% (8)	2.0% (1)	0.0% (0)	7.8% (4)	7.8% (4)	31.4% (16)	51

Note: AP= Activity Professionals, AT/MT= Art/Music Therapist, OT= Occupational Therapist, PT= Physical Therapist, RT= Recreational Therapist, SW= Social Worker, ST= Speech Therapist, NS= Nursing, PNS= Paid Non-Staff, V= Volunteer, *N*= total sample size

Table A5.

Correlational Relationships Between Medically Prescribed and Treatment Services

	Activity S. Medically Prescribed	Occupational T. Medically Prescribed	Physical T. Medically Prescribed	Recreational T. Medically Prescribed	Speech T. Medically Prescribed
Activity Services Medically Prescribed	1.000	---	---	.513**	---
Occupational Therapy Medically Prescribed	---	1.000	.747**	---	.787**
Physical Therapy Medically Prescribed	---	.747**	1.000	---	.811**
Recreational Therapy Medically Prescribed	.513**	---	---	1.000	---
Speech Therapy Medically Prescribed	---	.787**	.811**	---	1.000

Note: ** Correlation is significant at the .01 level.

Table A6.

Correlational Relationships Between Alternative Medicine and Treatment Services

	Activity S. Alternative Medicine	Occupational T. Alternative Medicine	Physical T. Alternative Medicine	Recreational T. Alternative Medicine	Speech T. Alternative Medicine
Activity Services Alternative Medicine	1.000	.146**	.156**	-.125*	.148**
Occupational Therapy Alternative Medicine	.146**	1.000	.967**	.539**	.949**
Physical Therapy Alternative Medicine	.156**	.967**	1.000	.532**	.963**
Recreational Therapy Alternative Medicine	-.125*	.539**	.532**	1.000	.516**
Speech Therapy Alternative Medicine	.148**	.949**	.963**	.516**	1.000

Note: ** Correlation is significant at the .01 level.
* Correlation is significant at the .05 level.

Table A7.

Correlational Relationships Between Interdisciplinary Team (IDT) and Treatment Services

	Activity S. IDT	Occupational T. IDT	Physical T. IDT	Recreational T. IDT	Speech T. IDT
Activity Services Interdisciplinary Team	1.000	.354**	.333**	-.358*	.350**
Occupational Therapy Interdisciplinary Team	.354**	1.000	.912**	.488**	.860**
Physical Therapy Interdisciplinary Team	.333**	.912**	1.000	.424**	.895**
Recreational Therapy Interdisciplinary Team	-.358*	.488**	.424**	1.000	.426**
Speech Therapy Interdisciplinary Team	.350**	.860**	.895**	.426**	1.000

Note: ** Correlation is significant at the .01 level.

Table A8.

Correlational Relationships Between Recreation-based Interventions (RBI) and Treatment Services

	Activity S. RBI	Occupational T. RBI	Physical T. RBI	Recreational T. RBI	Speech T. RBI
Activity Services Recreation-based Interventions	1.000	.333**	.242**	.424**	.252**
Occupational Therapy Recreation-based Interventions	.333**	1.000	.704**	.240**	.629**
Physical Therapy Recreation-based Interventions	.242**	.704**	1.000	.178**	.707**
Recreational Therapy Recreation-based Interventions	.424*	.240**	.178**	1.000	.153**
Speech Therapy Recreation-based Interventions	.252**	.629**	.707**	.153**	1.000

Note: ** Correlation is significant at the .01 level.

Table A9.

Correlational Relationships Between Downtime and Treatment Services

	Activity S. Down Time	Occupational T. Down Time	Physical T. Down Time	Recreational T. Down Time	Speech T. Down Time
Activity Services Down Time	1.000	.301**	.282**	.585**	.242**
Occupational Therapy Down Time	.301**	1.000	.879**	.440**	.841**
Physical Therapy Down Time	.282**	.879**	1.000	.410**	.873**
Recreational Therapy Down Time	.585*	.440**	.410**	1.000	.390**
Speech Therapy Down Time	.242**	.841**	.873**	.390**	1.000

Note: ** Correlation is significant at the .01 level.

Table A10.

Correlational Relationships Between Rigor of Education and Treatment Services

	Activity S. Rigor of Education	Occupational T. Rigor of Education	Physical T. Rigor of Education	Recreational T. Rigor of Education	Speech T. Rigor of Education
Activity Services Rigor of Education	1.000	.213**	.143**	.496**	.093**
Occupational Therapy Rigor of Education	.213**	1.000	.818**	.425**	.775**
Physical Therapy Rigor of Education	.143**	.818**	1.000	.345**	.798**
Recreational Therapy Rigor of Education	.496*	.425**	.345**	1.000	.333**
Speech Therapy Rigor of Education	.093**	.775**	.798**	.333**	1.000

Note: ** Correlation is significant at the .01 level.

Table A11.

Correlational Relationships Between Professional Cost and Treatment Services

	Activity S. Professional Cost	Occupational T. Professional Cost	Physical T. Professional Cost	Recreational T. Professional Cost	Speech T. Professional Cost
Activity Services Professional Cost	1.000	.229**	.172**	.521**	.183**
Occupational Therapy Professional Cost	.229**	1.000	.911**	.468**	.874**
Physical Therapy Professional Cost	.172**	.911**	1.000	.404**	.865**
Recreational Therapy Professional Cost	.521*	.468**	.404**	1.000	.409**
Speech Therapy Professional Cost	.183**	.874**	.865**	.409**	1.000

Note: ** Correlation is significant at the .01 level.

Administrative Perspectives of Recreational Therapy Services in North Carolina™

Consent form

I am a graduate student at the University of North Carolina at Greensboro requesting your participation in a research project involving health care facilities state-wide. The purpose of this study is to survey key administrative personnel to identify the rationale regarding what services (i.e., therapies, programs) currently are and are not being provided by health care facilities .The health care facilities involved in this study were obtained from the North Carolina Department of Health and Human Services (DHHS) website. You have been selected because of your administrative role within one of these facilities. Your participation will provide critical feedback which in turn could benefit patient care in health care facilities. In addition, you can choose to receive an executive summary of the study results. Information from this study will potentially expand knowledge and access to additional health care services. There are no costs to you or payments made for participating in this study. However, completion of this survey will make you eligible to win a gift card from Amazon.com. This survey will take approximately 15-20 minutes to complete.

Your privacy will be protected as you will not be identified by name or by facility as a participant in this survey. All data collected are anonymous and will be stored in a password protected computer accessible only by the researcher. All information obtained in this study is strictly confidential unless disclosure is required by law. Absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. In addition, Survey Monkey will not use the information collected from your surveys in any way, shape or form. The Institutional Review Board at the University of North Carolina at Greensboro has determined that participation in this study poses minimal risk to participants. If you have any concerns about your rights, how you are being treated or if you have questions, want more information or have suggestions, please contact Eric Allen in the Office of Research Compliance at UNCG at (336) 256-1482. Questions, concerns or complaints about this project or benefits or risks associated with being in this study can be answered by Laura Harkins who may be contacted at (717) 793-0687.

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is in a de-identifiable state. If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

By proceeding to the survey, you are agreeing that you have read this consent form, and you fully understand the contents of this document and are openly willing to consent to take part in this study. All of your questions have been answered. Feel free to print this consent form for your own records. By proceeding to the survey, you are agreeing that you are 18 years of age or older and are agreeing to participate in the research described to you above.

Facility and Services

This first set of questions will help us know a bit about your facility and its focus.

1. Please check your primary facility type.

- ◯ Hospital
- ◯ Psychiatric Hospital
- ◯ Skilled Nursing Facility
- ◯ Residential/Transitional
- ◯ Partial/Outpatient
- ◯ Other (please specify)

2. Please check the primary level of care at your facility.

- ◯ Long term care
- ◯ Rehabilitation
- ◯ Sub-acute
- ◯ Acute
- ◯ Other (please specify)

3. What age groups does your facility serve? Check all that apply.

- ☐ Pediatrics
- ☐ Adolescents
- ☐ Adults
- ☐ Older Adults

4. Number of beds in facility

5. Please indicate your primary source(s) of funding. Check all that apply.

- ☐ For profit
- ☐ Non-profit
- ☐ State/local government
- ☐ Federal government
- ☐ Other (please specify)

6. Which of the following does your facility bill? Check all that apply.

- ☐ Medicare
- ☐ Medicaid
- ☐ Private insurance
- ☐ Other (please specify)

7. Is your facility regulated by the Center for Medicare and Medicaid Services?

- ◯ Yes
- ◯ No
- ◯ I don't know

Opinions about Professional Services

8. Please indicate how familiar you are with the following professional services.

	Extremely familiar	Very familiar	Somewhat familiar	Slightly familiar	Not at all familiar
Activity Services	◯	◯	◯	◯	◯
Occupational Therapy	◯	◯	◯	◯	◯
Physical Therapy	◯	◯	◯	◯	◯
Recreational Therapy	◯	◯	◯	◯	◯
Speech Pathology	◯	◯	◯	◯	◯

9. Assume you had one new position available to support expanded services to clients. Please rank the following five professional types from 1 to 5, using 1 as your MOST preferred next hire and 5 as your LEAST preferred next hire.

	Most Preferred (1)	(2)	(3)	(4)	Least Preferred (5)
Activity Professional	◯	◯	◯	◯	◯
Occupational Therapist	◯	◯	◯	◯	◯
Physical Therapist	◯	◯	◯	◯	◯
Recreational Therapist	◯	◯	◯	◯	◯
Speech Therapist	◯	◯	◯	◯	◯

Opinions about Professional Services

For each of the following descriptive statements, please indicate your level of agreement with how well the descriptions fit each of the five identifed service types. Please mark an answer for each service.

10. This service is a medically prescribed therapy.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Activity Services	◯	◯	◯	◯
Occupational Therapy	◯	◯	◯	◯
Physical Therapy	◯	◯	◯	◯
Recreational Therapy	◯	◯	◯	◯
Speech Pathology	◯	◯	◯	◯

11. This service is an alternative medicine/therapy.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Activity Services	◯	◯	◯	◯
Occupational Therapy	◯	◯	◯	◯
Physical Therapy	◯	◯	◯	◯
Recreational Therapy	◯	◯	◯	◯
Speech Pathology	◯	◯	◯	◯

12. This service is a usual part of the interdisciplinary (treatment) team.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Activity Services	◯	◯	◯	◯
Occupational Therapy	◯	◯	◯	◯
Physical Therapy	◯	◯	◯	◯
Recreational Therapy	◯	◯	◯	◯
Speech Pathology	◯	◯	◯	◯

13. This service offers recreation-based interventions and/or activities.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Activity Services	◯	◯	◯	◯
Occupational Therapy	◯	◯	◯	◯
Physical Therapy	◯	◯	◯	◯
Recreational Therapy	◯	◯	◯	◯
Speech Pathology	◯	◯	◯	◯

14. This service mainly provide(s) clients with fun activities to do in their "down time."

	Strongly Agree	Agree	Disagree	Strongly Disagree
Activity Services	◯	◯	◯	◯
Occupational Therapy	◯	◯	◯	◯
Physical Therapy	◯	◯	◯	◯
Recreational Therapy	◯	◯	◯	◯
Speech Pathology	◯	◯	◯	◯

Opinions about Professional Services

15. In your opinion, how rigorous is the education/training that each of the following service professionals undergoes in order to practice?

	Extremely rigorous	Very rigorous	Somewhat rigorous	Slightly rigorous	Not at all rigorous
Activity professional	◯	◯	◯	◯	◯
Occupational therapist	◯	◯	◯	◯	◯
Physical therapist	◯	◯	◯	◯	◯
Recreational therapist	◯	◯	◯	◯	◯
Speech pathologist	◯	◯	◯	◯	◯

16. In your opinion, how costly is it to have each of these service professionals full time on staff at a facility like yours?

	Extremely expensive	Very expensive	Somewhat expensive	Slightly expensive	Not at all expensive
Activity professional	◯	◯	◯	◯	◯
Occupational therapist	◯	◯	◯	◯	◯
Physical therapist	◯	◯	◯	◯	◯
Recreational therapist	◯	◯	◯	◯	◯
Speech pathologist	◯	◯	◯	◯	◯

17. In your opinion, how beneficial is it to have each of these service professionals full time on staff at a facility like yours?

	Extremely beneficial	Very beneficial	Somewhat beneficial	Slightly beneficial	Not at all beneficial
Activity professional	◯	◯	◯	◯	◯
Occupational therapist	◯	◯	◯	◯	◯
Physical therapist	◯	◯	◯	◯	◯
Recreational therapist	◯	◯	◯	◯	◯
Speech pathologist	◯	◯	◯	◯	◯

Opinions about Professional Services

18. In your opinion, how difficult would it be for the following professionals to provide most or all of the services a Recreation Therapist is trained to provide?

	Extremely difficult	Very difficult	Somewhat difficult	Slightly difficult	Not at all difficult
Activity Professsionals	◯	◯	◯	◯	◯
Occupational Therapists	◯	◯	◯	◯	◯
Physical Therapists	◯	◯	◯	◯	◯
Speech Pathologists	◯	◯	◯	◯	◯

19. In your opinion, how much overlap is there between what Recreation Therapists do and what other service professionals do?

	Complete overlap with RT	Major overlap with RT	Moderate overlap with RT	Slight overlap with RT	No overlap with RT
Activity Professionals	◯	◯	◯	◯	◯
Occupational Therapists	◯	◯	◯	◯	◯
Physical Therapists	◯	◯	◯	◯	◯
Speech Therapists	◯	◯	◯	◯	◯

20. Please check the answer that indicates the extent to which you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree
Recreational therapists are required to have licensure in North Carolina.	☐	☐	☐	☐
Recreational therapy is another term for therapeutic recreation.	☐	☐	☐	☐
Therapeutic recreation services are only provided in community settings.	☐	☐	☐	☐

21. Regardless of whether you do or do not currently employ a Licensed Recreation Therapist (LRT) at your facility, please identify any potential benefits you see of having a Licensed Recreation Therapist (LRT) on staff.

Professional Services at Your Facility

This section will help us understand how healthcare facilities employ various professional services.

22. Please identify the different units that make up your facility and services you provide in each unit. Check all that apply. If your unit doesn't use any of the five services, leave them unchecked and move on to the next line.

	Activity Services	Occcupational Therapy	Physical Therapy	Recreational Therapy	Speech Pathology	We don't have this unit
Assisted Living	☐	☐	☐	☐	☐	☐
Behavioral/Mental Health	☐	☐	☐	☐	☐	☐
Memory Care	☐	☐	☐	☐	☐	☐
Oncology	☐	☐	☐	☐	☐	☐
Rehabilitation	☐	☐	☐	☐	☐	☐
Skilled Nursing	☐	☐	☐	☐	☐	☐

23. Identify how your facility matches or makes recommendations of each of the following types of service to individual patients/clients. Check all that apply.

	Service not Offered	Physician Referral	Nursing Referral	Case Manager Referral	Patient Request	Caregiver Request	Routinely offered to all clients
Activity Services	☐	☐	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐	☐	☐	☐
Recreational Therapy	☐	☐	☐	☐	☐	☐	☐
Speech Pathology	☐	☐	☐	☐	☐	☐	☐

24. Identify how your facility markets each service to the general public. Check all that apply. If you don't offer that service, leave the line unchecked and move on to the next line.

	Service is not marketed	Brochure	TV	Website	Phone recording while customers are on hold	Professional Referrals	Word of Mouth
Activity Services	☐	☐	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐	☐	☐
Physical Therapy	☐	☐	☐	☐	☐	☐	☐
Recreational Therapy	☐	☐	☐	☐	☐	☐	☐
Speech Pathology	☐	☐	☐	☐	☐	☐	☐

Activities, Programs and Therapies

The following questions ask you to identify activities, programs or therapies offered by your facility. We are also interested in who leads these activities.

If you do offer an activity, program, or therapy listed below, check any and all persons who deliver it. If the activity, program or therapy on any particular line is not offered at your facility, please go to the next line.

25. Focus on Physical Wellbeing

	Activity Professional	Art/Music Therapist On-Staff	Occupational Therapist	Physical Therapist	Recreational Therapist	Social Worker	Speech Pathologist	Nursing	Paid Non-staff	Volunteer
Active Games	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aquatic Therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Exercise & Movement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Outdoor Adventure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

26. Focus on Cognitive Wellbeing

	Activity Professional	Art/Music Therapist On-Staff	Occupational Therapist	Physical Therapist	Recreational Therapist	Social Worker	Speech Pathologist	Nursing	Paid Non-staff	Volunteer
Cognitive Stimulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Passive Games	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reailty Orientation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sensory Stimulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

27. Focus on Emotional Wellbeing

	Activity Professional	Art/Music Therapist On-Staff	Occupational Therapist	Physical Therapist	Recreational Therapist	Social Worker	Speech Pathologist	Nursing	Paid Non-staff	Volunteer
Behavior Modification	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Coping Skills	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Expressive Therapies (music, art, dance)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Humor Therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relaxation Therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

28. Multiple Client Needs

	Activity Professional	Art/Music Therapist On-Staff	Occupational Therapist	Physical Therapist	Recreational Therapist	Social Worker	Speech Pathologist	Nursing	Paid Non-staff	Volunteer
Animal Assisted Therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Community Reintegration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Horticulture Therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Leisure Education	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relapse Prevention	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Symptom Management	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Therapeutic Use of Magic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Licensed Recreation Therapist

The next sections will ask you questions more specifically related to your use of Recreational Therapists in your own facility.

29. Do you have a Licensed Recreation Therapist (LRT) at your facility?

◯ Yes

◯ No

Licensed Recreation Therapist Information

30. In the spaces provided, please identify the number of Licensed Recreational Therapists (LRT)and/or Licensed Recreational Therapist Assistants (LRTA) at your facility according to their PRIMARY roles.

# of LRTs who are administrators only

# of LRTs who provide direct treatment only

# of LRTs who have a blended role (equally administrative and direct treatment)

# of LRTAs who are administrators only

# of LRTAs who provide direct treatment only

# of LRTAs who have a blended role (equally administrative and direct treatment)

31. Which of the following types of people does the LRT at your facility supervise? Check all that apply.

- ☐ Other Licensed Recreation Therapists
- ☐ Activity Professionals
- ☐ Recreation Workers
- ☐ Volunteers
- ☐ N/A (The LRT at my facility is not an administrator/supervisor)
- ☐ Other (please specify)

32. What is the starting salary for a Licensed Recreation Therapist (LRT) at your facility?

- ◯ $20-25,999
- ◯ $26-30,999
- ◯ $31-35,999
- ◯ $36-40,999
- ◯ $41-45,999
- ◯ $46-50,999
- ◯ $51,000+

Licensed Recreation Therapist Information

33. My facility does not have a Licensed Recreation Therapist (LRT) on staff because...

	Agree	Disagree	I don't know
It was not warranted after performing a cost-benefit analysis.	☐	☐	☐
The budget does not permit a LRT on staff.	☐	☐	☐
We have been unsuccessful in finding an individual with the appropriate credentials.	☐	☐	☐
Recreational Therapy is not reimbursable.	☐	☐	☐
It is not needed at my facility.	☐	☐	☐

Other (please specify)

34. Although you do not have a LRT on staff, please identify who provides recreational therapy at your facility, if anyone. Check all that apply.

- [ ] Licensed Recreation Therapist Assistant(LRTA)
- [ ] Certified Therapeutic Recreation Specialist (CTRS)
- [ ] Activity Professional
- [ ] Occupational Therapist
- [ ] Physical Therapist
- [ ] Nursing Staff
- [ ] Recreation Worker
- [ ] Volunteer
- [ ] None of the above (My facility does not offer recreation therapy)
- [ ] Other (please specify)

35. Has your facility ever had a LRT on staff before?

- ◯ Yes
- ◯ No
- ◯ Don't know

Licensed Recreation Therapist Information

36. Why is there not a LRT on staff anymore?

DEMOGRAPHICS

37. Please indicate your job title

- ◯ CEO/President
- ◯ Vice President
- ◯ Administrator
- ◯ Program Director
- ◯ Director of Rehab Services
- ◯ Other (please specify)

38. Please identify your gender.

- ◯ Male
- ◯ Female

39. Please identify your age group.

- ◯ 18-25
- ◯ 26-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-60
- ◯ 61+

40. Please select from the following to indicate your primary race or ethnic background.

- ◯ Asian
- ◯ Black or African-American
- ◯ Caucasian
- ◯ Hispanic or Latino
- ◯ Native-American or Alaska Native
- ◯ Native-Hawaiian or other Pacific Islander
- ◯ Don't know or prefer not to answer
- ◯ Other (please specify)

41. If you wish to receive an executive summary of aggregate results from this survey, please provide your email in the space provided. By providing your email address, you are also entering the drawing for a gift card.

Email Address:

42. Comments: